Royal Commission into Victoria's Mental Health System

Final Report

Volume 2

Collaboration to support good mental health and wellbeing

Royal Commission into
Victoria's Mental Health System

Volume 2
Collaboration to support good mental health and wellbeing

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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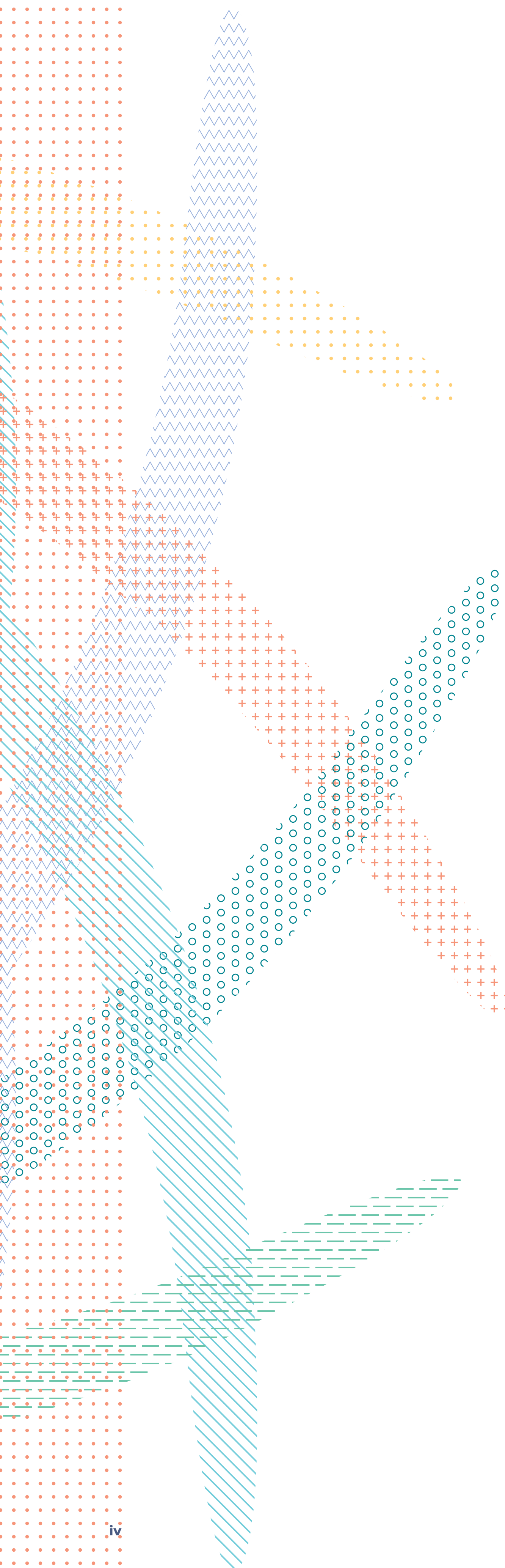
Acknowledgement of Aboriginal land and peoples

The heritage of Aboriginal communities throughout Victoria is vibrant, rich and diverse. We value these characteristics and consider them a source of strength and opportunity. We recognise that the leadership of Aboriginal communities and Elders in Victoria is crucial to improving outcomes for Aboriginal people. Also to be acknowledged, however, are the devastating impacts and the accumulation of trauma resulting from colonisation, genocide, the dispossession of land and children, discrimination and racism.

The Royal Commission into Victoria's Mental Health System proudly acknowledges Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. We acknowledge that Aboriginal communities are steeped in traditions and customs, and we respect this. We acknowledge the continuing leadership role of the Aboriginal community in striving to redress inequality and disadvantage, and the catastrophic and enduring effects of colonisation.

We recognise the diversity of Aboriginal people living throughout Victoria. Although the terms 'Koorie' and 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we use the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.

The Royal Commission is conscious that its work is taking place concurrently with renewed efforts to achieve constitutional recognition of Aboriginal peoples and treaty processes that are underway in Victoria. We commit to building on this momentum and to ensuring our work is shaped by the voice of Aboriginal people.



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A note on content

The Royal Commission recognises the strength of people living with mental illness or psychological distress, families, carers and supporters, and members of the workforce who have contributed their personal stories and perspectives to this inquiry.

Some of these stories and the Commission's analysis contain information that could be distressing. You might want to consider how and when you read this report.

Aboriginal readers are advised that this report may contain photos, quotations and/or names of people who are deceased.

If you are upset by any content in this report or if you or a loved one need support, the following services are available to support you:

- If you are not in immediate danger but you need help, call **NURSE-ON-CALL** on **1300 60 60 24**.
- For crisis support, contact **Lifeline** on **13 11 14**.
- For support, contact **Beyond Blue** on **1300 224 636**.
- If you are looking for a mental health service, visit **betterhealth.vic.gov.au**.
- **If you are in a situation that is harmful or life-threatening, contact emergency services immediately on Triple Zero (000)**.

Terminology and language

Language is powerful and words have various meanings for different people.

There is no single set of definitions used to describe how people experience their mental health. This diversity is reflected in the many terms used to capture people's experiences throughout the evidence put before the Commission.

As stated in the Commission's interim report, words and language can have a lasting impact on a person's life. They can empower and embolden. They can be used to convey hope and empathy. But they can also be divisive when used to dispossess and divide, and to stigmatise and label.

The Commission has considered the many perspectives on terminology, and acknowledges that language can be deeply contested and nuanced. Although it has at all times tried to use inclusive and respectful language, the Commission is aware that not everyone will agree with the terminology used.

Another consideration for the Commission has been this report's broad audience, including people with lived experience, their carers, families and supporters, workers in the mental health system, government and the wider Victorian community. This diverse audience needs to be able to read the report and understand its intent at this point in time in the development of the mental health system.

Below is a list of important terms in the report and how the Commission understands them. This list largely reflects the requirement to align with definitions outlined in the Commission's letters patent. It is also consistent with the Commission's interim report for the purposes of clarity.

Term	Definition
Carer	Means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.
Family	May refer to family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.

Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness or psychological distress but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health and wellbeing services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Psychological distress	One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.

The Commission only departs from these terms when referring to specific data sources, describing research works, or quoting an individual or organisation. The original language is retained wherever possible to accurately reflect the views and evidence presented to the Commission. For example, the Commission quotes individuals and organisations that sometimes refer to 'mental disorder', rather than the Commission's preferred terms of 'mental illness or psychological distress'. Terms such as 'disorder' can be pathologising and stigmatising, so the Commission only retains them if others use them to convey a specific meaning.

Personal stories and case studies

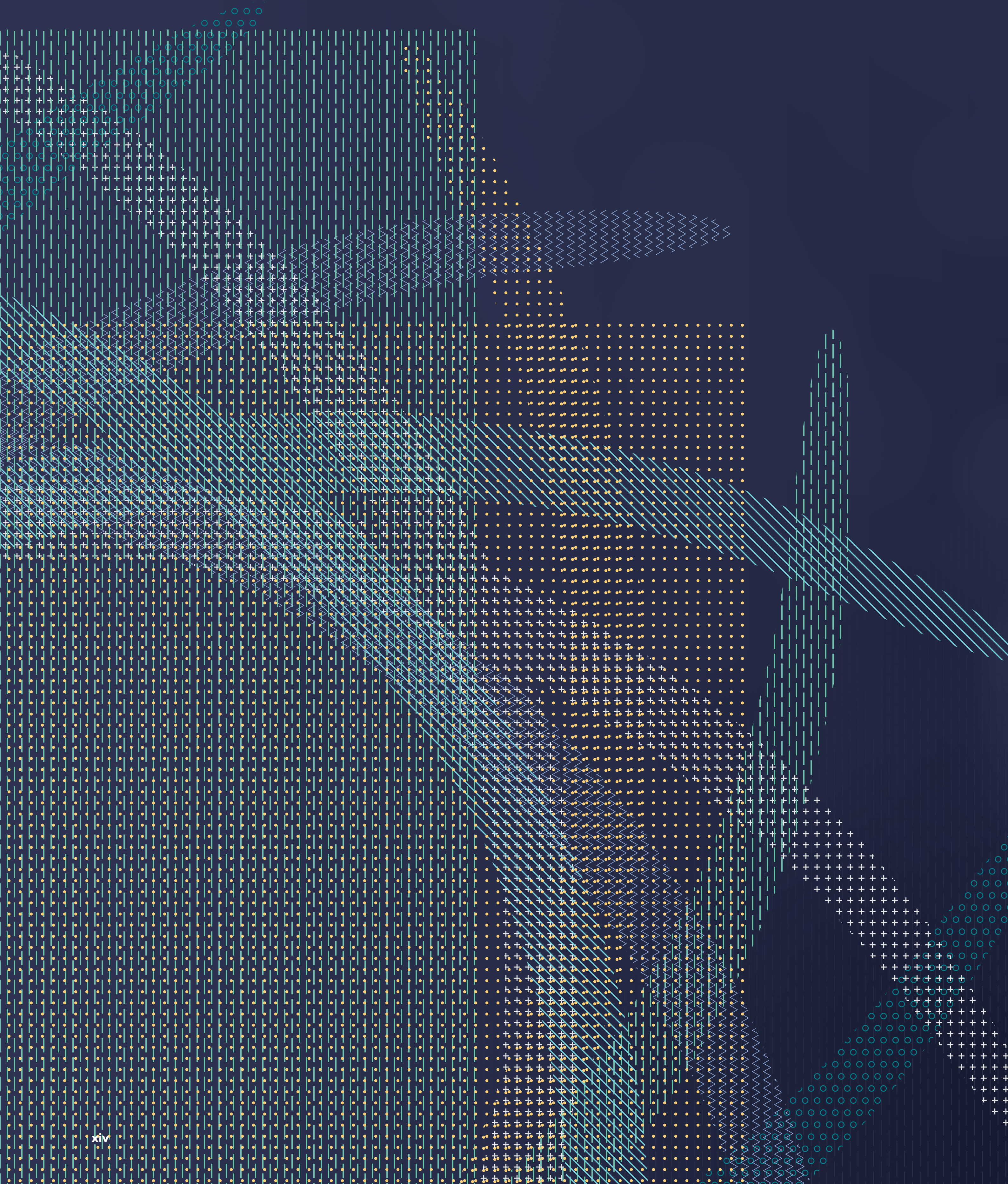
Throughout all phases of its work, the Commission has heard from people with lived experience of mental illness or psychological distress, families, carers and supporters, members of the workforce, organisations, experts and members of the broader Victorian community through consultations, submissions, correspondence, public hearings and witness statements.

Based on these sources, the Commission has included a selection of personal stories that appear throughout this report. These stories provide the individual's personal recollections of their interactions and experiences with Victoria's mental health system.

The Commission has also included a selection of case studies that are primarily about services or approaches that illustrate reform opportunities or innovation.

The Commission wanted to consider a broad range of ideas for improving the mental health system. Therefore, some of these personal stories and case studies include perspectives from outside of Victoria.

With the permission of the individuals involved, these have been modified for privacy and confidentiality where appropriate. In some instances, the Commission has also made non-publication orders to protect privacy and confidentiality.



Introduction

As required by the Commission's letters patent, the Commission was a policy-based inquiry. This report presents the findings from this process and sets out recommendations to inform the design of a new mental health and wellbeing system.

The Victorian community made more than 12,500 contributions to inform the Commission's work. The Commission has listened to this diversity of voices and analysed a wide variety of data and research. These inputs have illustrated the factors that shape people's experiences of mental health and wellbeing and have formed the basis for the design of the future system and services.

Volume 1 of this report outlines a new approach to providing Victorians with the right mental health treatment, care and support at the right time, and in the right places across the state. Volume 3 outlines reforms to promote inclusion and address inequities in the mental health and wellbeing system. Volume 4 explains the features that will ensure the system provides high-quality and safe services. Volume 5 sets out the enablers of system transformation, including the technology, information and expertise needed to make the system work effectively, and how it will drive continuous improvement.

This volume describes the collaboration and partnerships needed in the environments in which people live, work, learn and connect to promote good mental health and wellbeing. It also outlines an improved mental health and wellbeing system response for people of all ages. It explains how the system will work for infants, children and young people, and for older adults. It details major reforms that will provide an improved response for people who have experienced or are experiencing trauma, and for people who need supported housing. Finally, the volume describes the coordination required in the new system to implement wider strategies and actions on suicide prevention and response.

Partnerships that start where people work, learn and live

A variety of 'everyday' settings and places play an important role in promoting mental health and wellbeing including communities, workplaces and schools. Through local initiatives the Victorian Government will foster change in—and partner with—organisations in these settings to support social connection, to reduce stigma, and to raise awareness of and promote good mental health and wellbeing.

Workplaces will be better equipped to protect and promote the mental health of their workers. It will be easier for schools to use evidence-informed approaches that focus on mental health promotion and the prevention of mental illness and to build the strength and coping skills of children and young people to manage challenging times. Refer to Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect* for a detailed description of these reforms.

Supporting mental health and wellbeing across the life span

The mental health and wellbeing system will have increased capacity and will work flexibly to address the treatment, care and support needs for Victorians of all ages. Volume 1 describes the system for adults and older adults, and the service stream for adults. This volume describes the service stream for older adults. It also describes the system for infants, children and youth, and the two service streams within it.

The new system will support the mental health and wellbeing of the next generations through one infant, child and youth mental health and wellbeing system for newborns to 25-year-olds.

Community perinatal mental health teams will support prospective and new parents. A responsive and integrated service stream of treatment, care and support will support children from birth to 11 years and their families, focusing on the start of life and the formative years.

Victoria's young people, aged 12–25 years, will be supported to grow into adulthood with good mental health and wellbeing. A new youth mental health and wellbeing service stream will be established, with youth services being reformed and expanded in line with the Commission's core functions of community mental health and wellbeing services.

A detailed description of these reforms is provided in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* and in Chapter 13: *Supporting the mental health and wellbeing of young people*.

Older Victorians will be able to access the full range of treatment, care and support available to adults, and will be supported to maintain their independence and remain living in their local community. Older adults who are living with mental illness or experiencing psychological distress that is made more complex generally as a consequence of ageing will be able to access specialised treatment, care and support through a dedicated service stream.

A detailed description of these reforms is provided in Chapter 14: *Supporting the mental health and wellbeing of older people*.

Improving collaboration within and between systems

Collaborative approaches are fundamental to the Commission's vision for a transformed system, and a key pillar of the interim report was establishing the Collaborative Centre for Mental Health and Wellbeing. This volume promotes collaboration and how it can be used to better meet people's needs, including by improving responses to trauma, connecting people to housing, and ensuring a whole-of-community and whole-of-government approach to suicide prevention and response.

The Commission recognises the harmful and all-encompassing effects of trauma on individuals, families, carers, supporters and communities, and the need to intervene early. System and service responses to trauma must be improved.

The Victorian Government will establish a Statewide Trauma Centre, co-located at the new Collaborative Centre for Mental Health and Wellbeing. The trauma centre will deliver the best possible mental health and wellbeing outcomes for people affected by trauma and will provide ongoing support and coordination of specialist trauma practitioners embedded in selected mental health and wellbeing services.

These reforms are described in detail in Chapter 15: *Responding to trauma*.

The new system will also place greater emphasis on the relationship between mental illness and housing and the collaboration required between the mental health and wellbeing system and the housing and homelessness system. Safe and affordable housing plays a central role in supporting people living with mental illness to live well, with a sense of safety, security and belonging. In the future system, people living with mental illness will be recognised as a priority group in Victorian Government housing strategies, with an increase in the number and type of supported accommodation options for adults and young people living with mental illness. Refer to Chapter 16: *Supported housing for adults and young people* for details of these reforms.

Finally, the volume outlines how suicide prevention and response requires a collaborative approach across the community and government.

Many complex factors can lead to suicide, and these can often overlap. Agencies must come together across health, social services, education, industry and many more to respond to the interrelating factors that can lead to, or protect against, suicide.

The Victorian Government will establish a Suicide Prevention and Response Office, led by a State Suicide Prevention and Response Adviser, within the Department of Health. The office will establish a system-based approach to suicide prevention and response and implement a suite of suicide prevention and response initiatives.

Refer to Chapter 17: *Collaboration for suicide prevention and response* for a description of the governance approach and initiatives.

Overall, Victorians will experience improved mental health and wellbeing support across their life span as a result of stronger collaboration across communities, services and government outlined in this volume.

Chapter 11

Supporting good mental health and wellbeing in the places we work, learn, live and connect

Recommendation 15:

Supporting good mental health and wellbeing in local communities

The Royal Commission recommends that the Victorian Government:

1. establish and recurrently resource 'community collectives' for mental health and wellbeing in each local government area.
2. support each community collective to bring together a diversity of local leaders and community members to guide and lead efforts to promote social connection and inclusion in Victorian communities.
3. test and develop a range of initiatives that support community participation, inclusion and connection.
4. by the end of 2022, establish one social prescribing trial per region (refer to recommendation 3(3)) in Local Mental Health and Wellbeing Services to support healthcare professionals to refer people, particularly older Victorians, living with mental illness, into community initiatives.

Recommendation 16:

Establishing mentally healthy workplaces

The Royal Commission recommends that the Victorian Government:

1. as an initiative of the Mental Health and Wellbeing Cabinet Subcommittee (refer to recommendation 46(2)(a)):

    a. foster the commitment of employers to create mentally healthy workplaces;

    b. advise on, develop and provide resources to assist employers and employees across Victorian businesses to:

        - promote good mental health in workplaces;
        - address workplace barriers to good mental health;
        - promote inclusive workplaces that are free from stigma and discrimination; and
        - support people experiencing mental illness at work.

2. sponsor industry-based trials to demonstrate how to adapt and implement comprehensive mentally healthy workplace approaches in an industry context.

Recommendation 17:

Supporting social and emotional wellbeing in schools

The Royal Commission recommends that the Victorian Government:

1. fund evidence-informed initiatives, including anti-stigma and anti-bullying programs, to assist schools in supporting students' mental health and wellbeing.
2. develop a digital platform that contains a validated list of these initiatives.
3. develop a fund, modelled on School Readiness Funding for kindergartens, to support schools, with priority given to those in rural and regional areas, to select the most appropriate suite of initiatives for them.

11.1 Supporting good mental health and wellbeing in everyday settings

The places where we spend significant amounts of time have a profound impact on our mental health and wellbeing.[1] Our mental health and wellbeing is influenced by the streets, suburbs and neighbourhoods we live in, the places we go for prayer or worship, the parks and places we gather to socialise, the digital environments and online communities we interact with, our workplaces and our schools.[2] Our wellbeing is also influenced by our daily interactions with others, our capacity to socialise and connect, the communities we identify with and the people with whom we share a sense of belonging.[3] Witness Mr Jim Williamson highlighted the profound role our communities play in shaping mental health and wellbeing:

> **In particular, through social connection, society can provide each person with a sense of belonging and that they feel useful and competent—these are the powerful outcomes of social connectedness. The means to these outcomes include supportive relationships, involvement in community activities, providing opportunities for decision-making and civic engagement, and physical activity (among others).[4]**

Across their lives, almost all Victorians spend a significant amount of time participating in education, work and the broader community. In addition to the day-to-day influence that these environments have on mental health and wellbeing, the ability to participate and contribute in these settings increases opportunities for social, cultural and economic participation, which is in turn directly linked to positive mental health outcomes.[5] On the other hand, evidence indicates that exclusion from any of these settings can have adverse impacts on mental health.[6]

The importance of schools, workplaces and communities for mental health and wellbeing was highlighted in 2020, when measures to reduce the impact of the COVID-19 pandemic significantly limited Victorians' access to the places where so many people usually spend their time. Schools and early childhood settings were closed, and many students undertook remote learning. Social distancing and public gathering restrictions were enforced, and many workplaces ceased operations or were required to operate in significantly different ways.[7]

The impact of this on people's sense of social connectedness—and consequently mental health and wellbeing—was profound and will likely continue to be felt for some time. During the initial coronavirus restrictions, VicHealth surveyed 2,000 Victorians to examine how the restrictions were affecting health and wellbeing. Three in 10 respondents reported they found it hard or very hard to stay connected to friends and family during this period, and almost one in four did not feel connected with others.[8]

To help Victorians achieve optimal mental health and wellbeing, mental health promotion efforts must focus on the people and places that influence mental health and wellbeing in the first place. The COVID-19 pandemic has emphasised the importance of education, employment and community, and brought the link between these settings and mental health and wellbeing into sharp focus. Communities, workplaces and schools will always have a key role in our lives, even if the ways we interact with those settings change over time.

The Commission recognises that education, employment and community settings are promising sites for mental health promotion and efforts to prevent mental illness. They present opportunities to address the causes of poor mental health and to support good mental health by providing an inclusive and mentally healthy environment.[9] They also play an important role in supporting people who are living with mental illness or experiencing psychological distress, such as by assisting with navigation and access to mental health treatment, care and support, and because these are the key settings in which people can be supported to live a contributing life.[10]

Throughout its inquiry, the Commission was struck by the commitment of businesses, schools and community members to support better mental health and wellbeing outcomes. The resourcefulness and ingenuity of these groups in helping those most vulnerable in our communities and in driving a sense of connectedness and community spirit was truly heartening. The reform directions described in this chapter reflect the Commission's desire to build on the expertise, goodwill and determination of Victorians to drive change. It is the Commission's view that schools, workplaces and communities know their own communities best, and are therefore best placed to determine what is needed to support mental health and wellbeing. As such, the reforms in this chapter seek to ensure that schools, workplaces and communities across the state have the resources, infrastructure and support they need to continue to play a lead role in supporting good mental health and wellbeing.

11.2 Supporting good mental health and wellbeing through connection and community

Many people, in both personal and professional capacities, told the Commission of the critical link between communities, social connection and mental health and wellbeing.[11]

There are several ways to define communities. While communities are often defined by place and geographical boundaries,[12] people may also relate to a community through a shared sense of identity, activity or interest.[13]

Ms Lin Hatfield Dodds, Associate Dean for the Australian and New Zealand School of Government of the Crawford School, Australian National University, giving evidence in a personal capacity, reflected that:

> every community has a collectively curated culture and set of practices that holds it together. In formally constituted communities like sporting clubs, the culture and practices are more overt, while in informal communities like the local neighbourhood, the culture and shared practices are often unexamined. Whether examined or not, these elements of culture and practice frame how individuals relate and behave in a community.[14]

People also relate to and experience community through their ethnicity and cultural heritage. Ms Tanya Hosch, the Australian Football League's General Manager of Inclusion and Social Policy, described the importance of community for Aboriginal people:

> Connection to family and community and the culturally entrenched obligations to community are very strong and hardwired in Indigenous people. You can meet someone for the first time who almost automatically [becomes] like your mother or your father. If there's a bridge there it will be embraced freely; right from the start.[15]

The Commission recognises the many ways in which people define and relate to their communities. Unless specified otherwise, the Commission uses the term 'communities' in this chapter broadly, covering communities of place, identity, activity and interest.

11.2.1 Communities are at the heart of mental health and wellbeing

As part of its deliberations, the Commission held two workshops with community members from north-east Victoria and south-eastern Melbourne. The purpose of the workshops was for the Commission to understand—from the perspectives of community members—the role that communities of place, interest and identity play in supporting mental health and wellbeing.

Participants emphasised the role of communities in fostering relationships, and providing a sense of belonging and purpose. The sentiment that community is fundamental to mental health and wellbeing was one shared by many witnesses and is at the heart of the Commission's reforms.

The central role of communities in promoting good mental health and wellbeing has long been accepted in the field of public health. For example, communities were identified as a key setting in VicHealth's *A Plan for Action 2005–2007: Promoting Mental Health and Wellbeing*.[16] According to the World Health Organization's 2014 report on the *Social Determinants of Mental Health*, '[a]ction to support mental health at the community level provides a platform to develop and improve social norms, values and practices, while encouraging community empowerment and participation.'[17]

More recently, the Prevention Coalition's *Primed for Prevention: A Consensus Statement on the Prevention of Mental Disorders* identified 'strengthening communities to take action' as a key tool to address root causes of poor mental health,[18] demonstrating that communities remain an important setting for action.

Communities are also crucial for people with lived experience of mental illness. Witnesses and consumer-led organisations advocated to the Commission for a greater focus on communities to promote good mental health and wellbeing. Witness Mr Rod Jackson described the positive experience of his participation in his local Men's Shed, an organisation that aims to support the mental health and wellbeing of men:

> **Men don't always find it easy to talk about themselves and they don't want to burden you with their problems. The Shed is a great outlet for men to discuss mental issues, health concerns and just say to each other "are you ok"? It's like our video says: once you join a Shed you have 100 friends. The Shed helps men connect and have company.**[19]

Personal story:

David Pearl

Photo credit: Else Pearl

David uses the arts to inspire positive social change and creativity in business. He said he had experienced depression since childhood but had 'stopped seeing it'.

David's second suicide attempt as a young adult led to him being admitted to a hospital and was a turning point for him because what he had been feeling was suddenly 'out there'.

He notes his time in hospital sowed the seeds for the many things he has done since.

> I wouldn't wish depression upon anybody, but the experience turned out to be very, very significant and helpful in unexpected ways.
>
> Magical stuff can happen in even the most difficult or odd circumstances.

David's work now focuses on bridging the gap between the arts and business.

> Performance is at the heart of mental stress at work, because performance is often synonymous with delivery.
>
> One of the reasons there's so much mental stress and suffering in work life is that there is no rehearsal space. There is no legitimate time or place for people to get it wrong, to try different things.

Even in David's own work he acknowledges there is performance.

> That is the front stage me. The onstage me. What you don't see and what I don't often talk about ... is what is in the back stage.
>
> My past experiences of despair have been a constant source of insight – a motor really – as I perform on the various stages of my life ... but they've remained in my backstage.

David believes storytelling is a powerful medium to drive change and reduce stigma. Much of David's work centres around the power of narrative.

> At the personal level ... the story you tell yourself about your past and your future has an enormous effect on your mental health and your general wellbeing.

> The second level on which storytelling can drive change is the public level. It's the story that organisations, institutions and governments tell about mental wellness. Just including these words in the daily currency of business makes it much more possible to talk about them.

David believes the most powerful example of using storytelling to reduce stigma is when leaders talk about their own mental health. David said that this can:

> [broaden] the definition of what a leader is and should be: a feeling human, who experiences ups and downs.

David is also the co-founder of Street Wisdom, a social enterprise that aims to connect people and their environment. Street Wisdom pushes the boundaries of engagement with community by teaching people to use their immediate environment to find inspiration.

> Street wisdom is about creating an atmosphere of social cohesion … That the answer to our mental health—and our survival—is collective.

Street Wisdom offers 'WalkShops' in more than 70 countries (both in person and online), based on the idea that wisdom is all around us, if we know how to look for it. WalkShops take participants on a journey through the streets, based on principles of psychology, creativity, mindfulness and cognitive science.

Guided by a 'Street Leader', participants 'tune': you awaken your senses. Second, you 'ask' yourself a question and wander the streets alone to find an answer and finally, come together to 'share' what you found.

David said the key to answering some of our own questions is paying attention to our surroundings.

> Where is our attention most of the time when we are walking around the streets? Our attention is inwards.
>
> What we are saying at Street Wisdom is take your attention and put it out … we say it is the kind of school where you don't pay fees, you pay attention.

David observed that people are more well when they feel like they belong to something. While each person takes an individual journey through the streets, their own journey connects them with others at the end, bringing a sense of social cohesion.

> appreciation is an antidote to misery. Because if you can appreciate the moment, then it's very difficult to be depressed about it. You can appreciate that—whilst life isn't necessarily what you want it to be—I'm alive.

Source: *Witness Statement of David Pearl*, 11 May 2020; David Pearl, <www.davidpearl.net>, [accessed 25 June 2020]; Street Wisdom, <www.streetwisdom.org> [accessed 25 June 2020]; 'Street wisdom: David Pearl at TEDxAUBG' <www.youtube.com/watch?v=xYlAIpHjlsw> [accessed 25 June 2020]; 'David Pearl, The Inspire Movement', <www.youtube.com/watch?v=955DZWa1G4M> [accessed 25 June 2020].

Ms Mary O'Hagan MNZM, Manager Mental Wellbeing, Te Hiringa Hauora, New Zealand, giving evidence in a personal capacity, noted that people with lived experience of mental illness find community supports critical:

> I have found that, when you ask people, 'What helped you recover?', psychiatry is usually only a small part of their answer, if it features at all. For most people, the things that are really important are having a job, forming friendships, finding a house and feeling better about yourself. However, the way our systems are funded, most of the funding goes into pills and pillow services and only a little bit goes towards all these other things that people find very important.[20]

Consumer-led organisations also advocated for a greater focus on communities as a setting for prevention and early intervention efforts. As the Victorian Mental Illness Awareness Council described:

> Recognising social determinants and the right to health means that 'early intervention' cannot be about diagnosis and prescribing. Instead it must be about compassion, therapeutic responses to the things in our world that hurt people's hearts and minds. Things like supporting communities to support each other.[21]

These consumer viewpoints have been influential in the Commission's deliberations. The Commission accepts that communities must be at the centre of reform efforts, given they are where people spend most of their time, seek the majority of their support, and gain an important sense of meaning and purpose. Put simply, communities are at the heart of good mental health and wellbeing, and they should therefore be at the heart of endeavours to achieve better mental health and wellbeing outcomes for all.

11.2.2 Communities are central to the Commission's reforms

In considering the role of local communities in reform efforts, the Commission took interest in the *Wellbeing Manifesto for Aotearoa New Zealand*. The Wellbeing Manifesto was produced as a submission to the 2018 New Zealand Government Inquiry into Mental Health and Addiction. It was developed by Ms O'Hagan in partnership with New Zealand lived experience experts.

The Wellbeing Manifesto advocated for community to be at the centre of mental health and wellbeing efforts.[22] It called for a comprehensive range of services and supports for people with 'mental distress', as well as for the broader population, to contribute to whole-of-population wellbeing and to help the population to take care of their own and each other's health.[23] It asserted:

> We must restart the journey to Big Community and resist pressure to pour more resources into the current obsolete model. Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress and addiction has open access to a comprehensive range of responses.[24]

Personal story:

Rick Corney

Rick first experienced mental health challenges when he was 28 years old. Following several involuntary hospitalisations, he was diagnosed with schizophrenia.

> It was devastating. I didn't understand the illness ... I lost all hope of being well.

After his diagnosis, Rick became clinically depressed and suicidal. He credits his mum with the fact that he is still here today, saying she played an important role in supporting him throughout his treatment.

> She went beyond and above what I thought possible.
>
> I look back now ... there was no carer's network when she was supporting me.

Support also came directly from Rick's community after a friend of his mum's told members of the local cricket club about his situation. Rick believes the community at the cricket club was critical to his recovery.

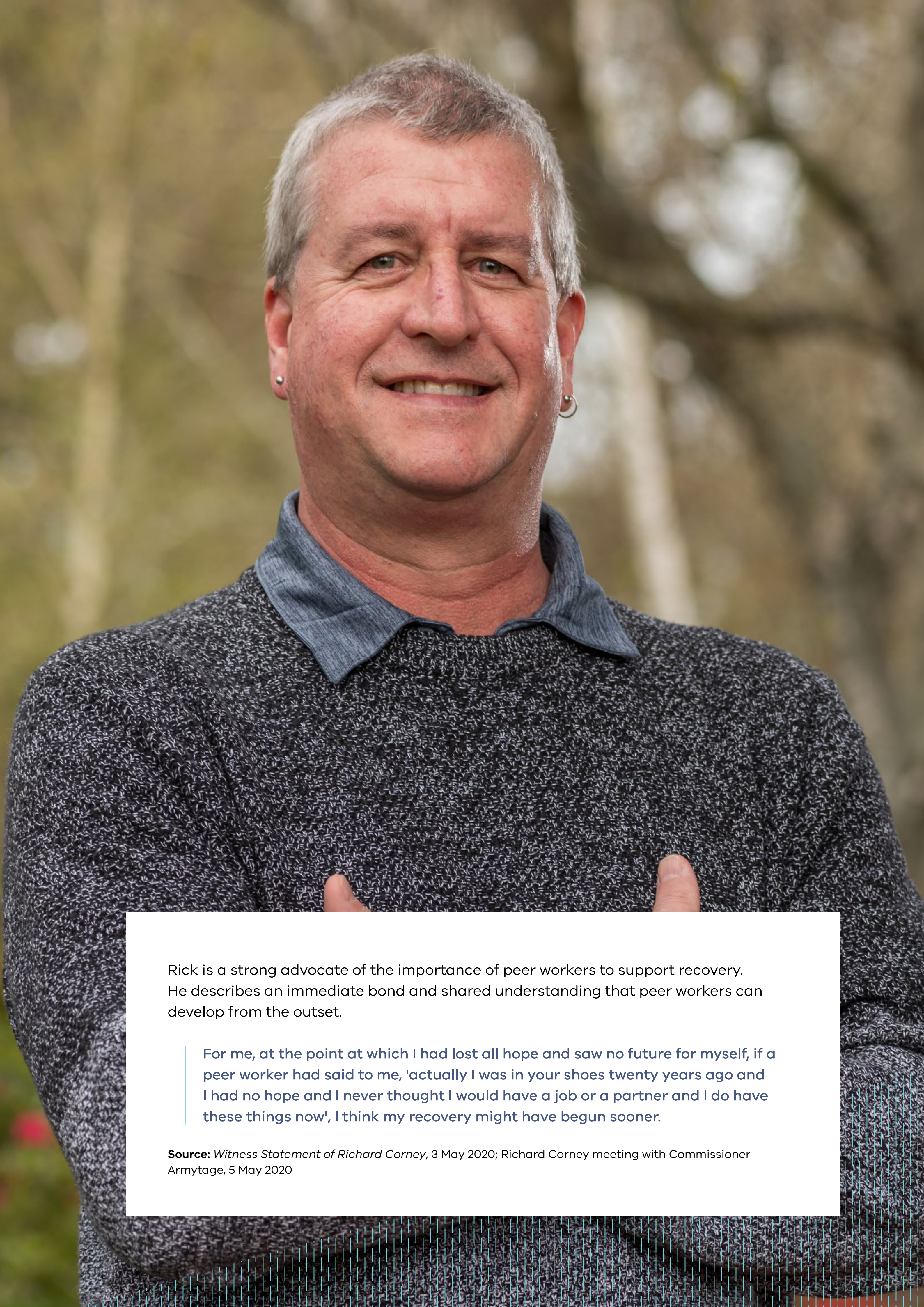
> They ended up coming and picking me up every Saturday to take me to the cricket. The first season I was so unwell and couldn't play, so they sat me behind the bar and the only thing I said was '$2.50 thanks', every time I sold a beer ... We still laugh about that today, and about how far I've come.

While in the early days Rick experienced some stigma at the club, he believes this came from a lack of understanding about mental illness. Over time, instead of being the face of mental illness, he moved to being the face of what recovery can look like.

> the cricket club has taken their learning out of my experience which has helped raise awareness. It has been really powerful ... now people are able to talk about issues they are facing without feeling as though they are going through things alone and keep things hidden like I did.

Rick is now a peer worker at a mental health service in Ballarat. He sees his story as a powerful message to share with others to inspire them, demonstrating that 'anything is possible'.

> The fact that I'm here ... kicking these goals and doing what I'm doing now ... is a testimony to what recovery is about, and it's the gold standard of how life can change.

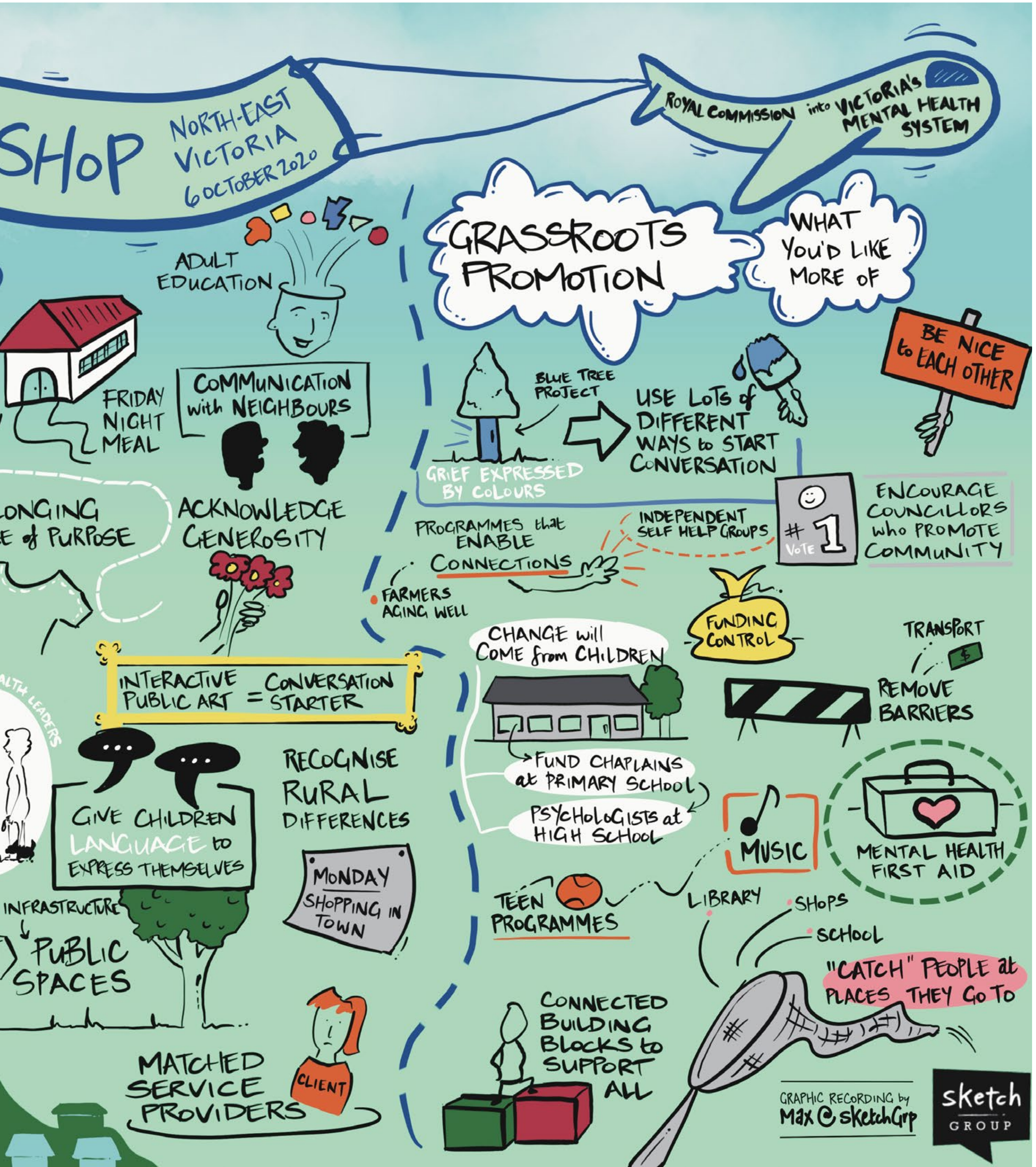


Rick is a strong advocate of the importance of peer workers to support recovery. He describes an immediate bond and shared understanding that peer workers can develop from the outset.

> For me, at the point at which I had lost all hope and saw no future for myself, if a peer worker had said to me, 'actually I was in your shoes twenty years ago and I had no hope and I never thought I would have a job or a partner and I do have these things now', I think my recovery might have begun sooner.

Source: *Witness Statement of Richard Corney*, 3 May 2020; Richard Corney meeting with Commissioner Armytage, 5 May 2020

Figure 11.1: Graphic representation of the north-east Victoria mental health and wellbeing community workshop


SHOP NORTH-EAST VICTORIA 6 OCTOBER 2020
ROYAL COMMISSION into VICTORIA'S MENTAL HEALTH SYSTEM
ADULT EDUCATION
GRASSROOTS PROMOTION
WHAT YOU'D LIKE MORE OF
BE NICE to EACH OTHER
FRIDAY NIGHT MEAL
COMMUNICATION with NEIGHBOURS
BLUE TREE PROJECT
USE LOTS of DIFFERENT WAYS to START CONVERSATION
GRIEF EXPRESSED BY COLOURS
ENCOURAGE COUNCILLORS who PROMOTE COMMUNITY
#1 VOTE
ACKNOWLEDGE GENEROSITY
PROGRAMMES that ENABLE CONNECTIONS
INDEPENDENT SELF HELP GROUPS
FARMERS AGING WELL
FUNDING CONTROL
TRANSPORT
CHANGE will COME from CHILDREN
INTERACTIVE PUBLIC ART = CONVERSATION STARTER
REMOVE BARRIERS
RECOGNISE RURAL DIFFERENCES
FUND CHAPLAINS at PRIMARY SCHOOL
PSYCHOLOGISTS at HIGH SCHOOL
GIVE CHILDREN LANGUAGE to EXPRESS THEMSELVES
MONDAY SHOPPING IN TOWN
MUSIC
MENTAL HEALTH FIRST AID
INFRASTRUCTURE
PUBLIC SPACES
TEEN PROGRAMMES
LIBRARY
SHOPS
SCHOOL
"CATCH" PEOPLE at PLACES THEY GO TO
CONNECTED BUILDING BLOCKS to SUPPORT ALL
MATCHED SERVICE PROVIDERS
CLIENT
GRAPHIC RECORDING by Max @ sketchGrp
sketch GROUP

The reforms in this chapter have been designed to enable community groups and community members to support the mental health and wellbeing of local communities. The crucial role of community in mental health and wellbeing is a key theme throughout the Commission's entire suite of reforms, for example:

- recognising the importance of providing mental health services close to people's homes, Local Mental Health and Wellbeing Services will be founded in local communities, with the delivery of services and supports tailored to local circumstances which is detailed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*
- the establishment of a new agency led by people with lived experience of mental illness or psychological distress which will provide opportunities for the Victorian community to come together and better understand the diverse, rich and powerful experiences of consumers is detailed in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*
- the establishment of a new Mental Health and Wellbeing Promotion Office within the Department of Health, which will support the delivery of whole-of-population communications efforts and community-level action for mental health and wellbeing is detailed in Chapter 4: *Working together to support good mental health and wellbeing*
- support for community-led organisations and community members to deliver projects to challenge stigma is detailed in Chapter 25: *Addressing stigma and discrimination*
- flexible funding for Victoria's diverse communities to deliver mental health information, literacy and navigation to the mental health and wellbeing system is detailed in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*.

11.2.3 Communities can influence the factors that shape mental health

Research indicates that many different factors affect mental health and wellbeing. Public health and mental health experts refer to these as 'risk' and 'protective' factors.[25] VicHealth's submission to the Commission presented research showing risk and protective factors for mental health, which spanned social determinants of health such as access to income and housing, as well as individual factors.[26] Some of these factors can be influenced by communities, including social connectedness, social isolation and loneliness.

Social connection and inclusion

According to VicHealth, '[s]ocial connections comprise the people we know, the friends we confide in, the family we belong to and the community we live in. These connections provide a level of social support that is critical for mental health and wellbeing.'[27] Social connection also contributes to the creation of social capital within communities, in that it builds networks of support that can assist people in times of need.[28]

As one participant at the community workshop in north-east Victoria said:

> Yeah, I think good mental health is governed by relationships, whether they're good or bad. And we need relationships, we're fundamentally a social people. So we need a connection with other people to develop our plans, our hopes, our dreams, our ambitions. And unfortunately, without those relationships, then things don't go too well.[29]

The relationship between social connection and mental health and wellbeing is described in literature. A 2015 systematic review of the link between social relationships and depression found that people have lower levels of depression than others in the population if they have personal relationships they can call on to provide support or offer practical or material assistance.[30]

Social connection and social inclusion are related, yet distinct, concepts. Ms Hatfield Dodds explained to the Commission that 'social inclusion is a population or community-level approach to not leaving anybody behind'.[31] Ms Hatfield Dodds said:

> The more inclusive a community is, the more positive the correlation is with health outcomes, including mental health outcomes. If a socially inclusive community is defined as one in which we all take responsibility for ensuring that everyone can reach their potential, individually and collectively, and feels that they belong and are valued, experience and evidence from around the world suggests this will optimise physiological health, mental health and emotional wellbeing of its members.[32]

Social isolation and loneliness

Giving evidence in a personal capacity, Mr David Pearl, Innovator, Author and Public Speaker of The Studios, London, said that 'there are people in plain view who are in fact isolated. That is a major problem because this kind of isolation is not evident at first glance'.[33] This reflects research that suggests it is possible to be surrounded by others but still feel lonely.[34]

Where social isolation is defined as having minimal contact with others, loneliness is defined as a subjective feeling of distress people experience when their social relations are not the way they would like.[35] The experience of loneliness, therefore, is not necessarily related to the frequency of social activities, or the amount of time spent alone.[36]

Rates of loneliness in Australia are confronting. According to the 2018 *Australian Loneliness Report*, one in four Australian adults is lonely, and one in two Australians feel lonely for at least one day in a week.[37]

Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne said, '[p]oor social relationships are linked to poorer health practices and to psychological processes, such as stress and depression.'[38]

People who are lonely have poorer physical and mental health outcomes than people who feel connected to others. People experiencing loneliness are 15.2 per cent more likely to be depressed and 13.1 per cent more likely to be anxious about social interactions than those who are not lonely.[39] A systematic review of the public health consequences of social isolation and loneliness suggested a positive relationship between high-quality social relationships and subjective wellbeing across all ages.[40]

The COVID-19 pandemic highlighted the harms associated with social isolation and loneliness and underscored the value of communities. It is likely that many mental health impacts associated with the pandemic have yet to fully manifest. Mental health experts anticipate a 'second wave' of mental health consequences as a result of widespread restrictions and associated social isolation.[41]

As Professor Patrick McGorry AO, Professor of Youth Mental Health at the University of Melbourne and Executive Director of Orygen, who gave evidence in personal capacity explained:

> COVID-19 is different to other global disasters that have preceded it because it has forced us to behave in complete opposition to our need of societal and physical connections with each other. It is very damaging for our mental health. There is a strong evidence base on the importance of attachment and loss ... Many of the protective factors that we rely upon to keep ourselves mentally healthy have been stripped away and we are trying to survive.[42]

Some people are at higher risk of social isolation and loneliness than others. Witness Mr Dave Peters described his experience of isolation, '[l]iving with a chronic mental illness can quickly become incredibly isolating. In an age of social media and COVID-19, I've become extremely isolated even with tele- or remote access supports'.[43] In its submission, Carers Victoria informed the Commission that carers also experience social isolation and associated poorer health outcomes at rates higher than other people.[44]

The Commission also heard that older people are at significant risk of loneliness.[45] A population-based survey of loneliness in older adults from the United Kingdom indicated that increased rates of loneliness were associated with greater severity of depressive symptoms in the 12-year follow-up.[46] The research also suggested that 11–18 per cent of cases of depression could potentially be prevented if loneliness was eliminated.[47] The impact of loneliness for older adults is detailed in Chapter 14: *Supporting the mental health and wellbeing of older people*.

Stigma, discrimination and social exclusion

Stigma describes the process of labelling differences, linking those labels to negative stereotypes and shaming, 'othering' or devaluing individuals based on these stereotypes.[48] Discrimination describes the process of a person or organisation treating someone unfavourably because of a particular attribute.[49] Stigma and discrimination can occur against many attributes, including mental illness, and may target multiple overlapping identities—sometimes referred to as intersectionality.[50] All forms of stigma and discrimination cause harm to mental health.[51] Chapter 25: *Addressing stigma and discrimination,* describes these concepts in detail.

Stigma and discrimination can result in an individual being excluded from many aspects of society.[52] Social exclusion describes the process of being shut out from the social, economic, political and cultural systems that help a person integrate into the community.[53] There is a recognised link between poor mental health and social exclusion.[54] In its submission, the Brotherhood of St Laurence explained that social exclusion can lead to poor health outcomes in general, and to disproportionately poor outcomes for certain groups.[55]

The *National Stigma Report Card*, a comprehensive study of Australians living with mental illness, indicates that people with mental illness withdraw themselves from public spaces at high rates.[56] Seventy-two per cent of respondents said they had stopped themselves from accessing opportunities for participation in sports, community groups or volunteering because of stigma and discrimination about mental illness.[57] The report suggested that stigma and discrimination compounds the isolation of people who experience mental illness and compromises 'psychosocial recovery' by limiting opportunities to connect.[58]

Social exclusion, often in the form of racism or vilification, has a considerable impact on culturally diverse groups in the Victorian community. Professor Moodie explained that newly settled or arrived people typically have the least power and resources in society and are often blamed by the press for their predicament. This has resulted in 'disengagement particularly for young people, as well as poor mental health and impacts on not only the mental health systems but the justice and welfare sectors as well'.[59] The Scanlon Foundation's *Mapping Social Cohesion* report outlined that from 2007 to 2017, the proportion of respondents who reported discrimination 'because of skin colour, ethnic origin or religion' more than doubled, from 9 per cent to 20 per cent.[60]

The Victorian Commissioner for Gender and Sexuality (now known as the Commissioner for LGBTIQ+ Communities) Ro Allen gave an account of the discrimination, prejudice and social exclusion that is experienced by LGBTIQ+ communities. Commissioner Allen explained that these experiences:

> can result in intensely negative feelings such as shame, hostility and self-hatred. Furthermore, lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with their family or minimal contact with little to no support. This is likely to be higher for trans and gender diverse people.[61]

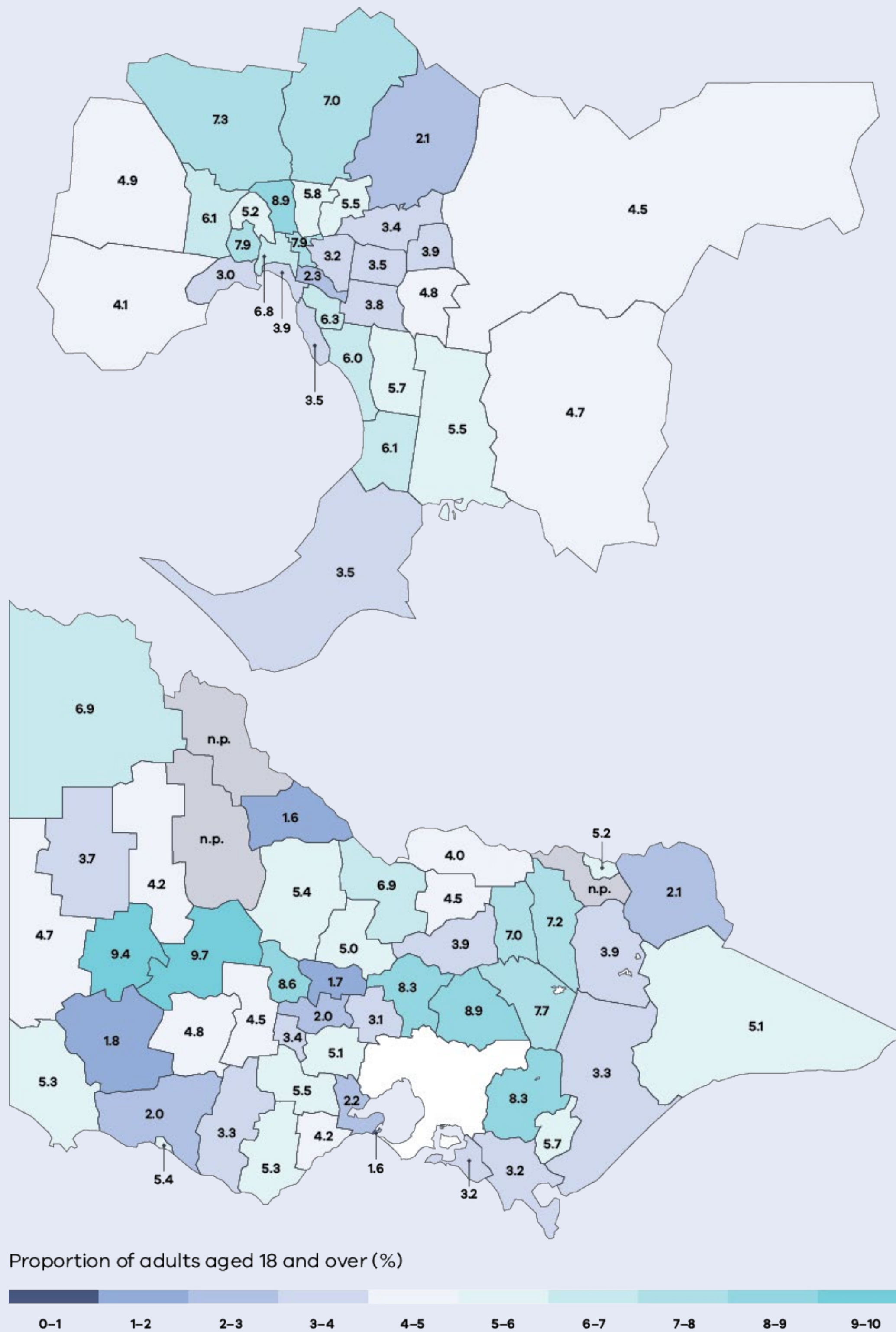
Commissioner Allen emphasised that these impacts on mental health are not felt by LGBTIQ+ communities by virtue of their identity, but rather because of experiences of discrimination and social exclusion,[62] which have lasting impacts on mental health.[63] The mental health of LGBTIQ+ communities is detailed in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*.

Community-level risk and protective factors across the state

Indicators of community-level mental health risk and protective factors suggest that there is wide variability in communities across Victoria. As detailed in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria,* many rural and regional communities across Victoria are characterised by strong social bonds and a spirit of social connectedness.[64] Mr Williamson described Footscray, in metropolitan Melbourne, as a 'remarkably resilient community,'[65] which stemmed from 'its strong working-class origins and family connectedness, complemented by a series of new cultural groups coming in and helping to build its business and community life'.[66]

Figure 11.2 illustrates the variability of protective factors across the state, using one indicator relevant to social connection and inclusion as an example: the proportion of people who said they were not, or were not often, able to get help from friends.

Figure 11.2: Proportion of adults that said they did not, or did not often, have the ability to get help from their friends, Victoria, 2014



Source: Department of Health and Human Services, *Victorian Population Health Survey 2014: Victorian Population Health Survey 2014: Quick statistics at local government area,* <www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey/victorian-population-health-survey-2014>, [accessed 23 November 2020].

Note: n.p. indicates not published because of small numbers.

In this example, many rural and regional areas show positive outcomes against this indicator, with fewer people indicating they were unable to get help from their friends. However, this is not uniform across Victoria, with several local government areas, particularly in central-western Victoria, demonstrating less favourable outcomes. This data shows that at an aggregate level, the presence of protective factors can vary greatly between bordering communities.

Population indicators, disaggregated by local government area, can help local communities and governments understand areas of community strength, identify where challenges persist, and test community thinking around where efforts should be focused. Data also provides insights as to where community-level mental health risk and protective factors may be able to be addressed by local interventions or initiatives.

Data can have limitations, particularly where insufficient data is collected in relation to the experiences of Victoria's diverse communities. However, combined with local intelligence, data can be a valuable source of information for local communities. As part of the reforms outlined in this chapter, it is proposed that the Mental Health and Wellbeing Promotion Office and local councils work together to collate, interpret and share local data with the community to help inform local mental health promotion and prevention efforts.

In the context of emergency preparedness and recovery, data can also provide a source of information to help communities and governments proactively predict and address community needs before or after a disaster or disruption. *The Australian Natural Disaster Resilience Index* report noted that:

> **Australian communities are also affected by various factors which enhance or constrain their capacity for disaster resilience. The particular combination of factors that influence capacity for disaster resilience differs from place to place. This generates a heterogeneous and complex picture of the factors associated with disaster resilience in Australia.**[67]

Professor Louise Harms, Chair and Head of the Department of Social Work at the Melbourne School of Health Sciences, University of Melbourne, emphasised in her personal capacity, the critical importance of community-building measures to reduce the impact of poor mental health in the event of an emergency:

> **For communities, the more that can be done preventatively the better. Communities can build community infrastructure through activities such as football clubs, book clubs and social groups. It helps when a community has a leadership hierarchy that can be established through non-disaster focused means and leveraged in times of disaster.**[68]

11.2.4 Creating better pathways between the mental health and wellbeing system and communities

The Commission considers that social prescribing has the potential to strengthen future pathways between mental health and wellbeing services and the community.[69] Social prescribing is the process of healthcare professionals connecting people with non-clinical community groups and supports.[70] For example, this might entail health professionals referring people to arts and creative activities, social groups, nature-based activities, physical activity, education or volunteering as part of their recovery plan.[71]

Several submissions to the Commission identified the potential of social prescribing. The Consumers Health Forum of Australia noted, '[w]e believe social prescribing offers the Australian system considerable promise and its implementation should be the subject of a nationally evaluated trial in the first instance.'[72] SANE Australia recommended increased 'availability of multi-modality team structures to better support the assessment and response of the biological, psychological and social needs of people affected by complex mental health issues', and identified social prescribing as one innovative tool to achieve this.[73] The Neighbourhood Houses Victoria submission noted that:

> There is an opportunity to adopt the use of social prescribing and increase awareness of the Neighbourhood Houses and similar sectors such as Men's Sheds amongst health professionals and other mental health services as well as the general public.[74]

Connecting2community is a community mental health program delivered by peer workers which aims to connect people with lived experience to their communities. The service is provided by Ballarat Community Health and Grampians Community Health and funded by the Western Victoria Primary Health Network.[75] Mr Rick Corney, Witness, described the program:

> We wanted to get a peer worker who is sort of like an icebreaker to connect the person back to the community … We also ask people to identify what their first goal is, what are the barriers for them and how we can assist the client to achieve their goal. The sessions could focus on joining an art group, going back to work or having a medication review, any realistic goal.[76]

The Commission considers that social prescribing might be a particularly useful tool to prevent and address loneliness experienced by older Victorians. As identified in the Commission's aged persons mental health services roundtable, social prescribing can help link older Victorians to existing initiatives in the community that support increased social connection (such as the University of the Third Age and Men's Sheds).[77] Additionally, the Royal Australian College of General Practitioners identified older people as well suited to social prescribing, as this group is particularly likely to experience increased loneliness due to the loss of social connections at this time in life, and experience significant life events that may contribute to isolation, including the loss of a loved one.[78]

While social prescribing has delivered some promising results internationally and one trial is progressing in Victoria, the academic evidence base to support this approach is not yet conclusive.[79] In November 2019, a rapid literature review was completed to inform the Royal Australian College of General Practitioners and Consumers Health Forum of Australia's social prescribing roundtable. It noted 'uncertainty and difficulty in assessing the effectiveness of [social prescribing], as reported in the peer-reviewed literature. Quantitative outcome studies were few and showed inconsistent results'.[80] Based on these results, the Commission recommends trialling social prescribing in the Victorian context to expand the local evidence base (refer to section 11.2.8).

11.2.5 Strengthening communities is critical to mental health and wellbeing

The Commission has witnessed firsthand the drive, passion and capability of community members to create change at the local level, and it recognises that community members across the state have the appetite and aspiration to do more to improve mental health and wellbeing.[81] Mr Williamson reflected that community initiatives currently play a critical role in promoting good mental health and wellbeing:

> I think there is a lot happening in this space where community groups and initiatives do seek to work closely with local residents experiencing mild, or not yet recognised experiences of poor mental health. It is important to recognise that all these community groups have been contributing to the glue that has held the mental health system together, and they could have an expanded role in a reformed and more responsive system.[82]

Professor Moodie identified a range of promising initiatives that facilitate social connection, including community gardens, Men's Sheds and Vocal Nosh (a monthly community event that brings people together to sing and share a meal). He noted that:

> It is vital that we reinforce effective community-based initiatives like these and continue to adequately invest in them. These initiatives play a vital role in connecting people and offering people the tools they need to engage with and feel included in society.[83]

Witness Mr Titan Debirioun established a recording studio in his home in the west of Melbourne to give young people from his local area the chance to learn about and participate in music production. This music program became so popular that it outgrew Mr Debirioun's home. To reach more young people, the program partnered with the Centre for Multicultural Youth and Multicultural Health Victoria.[84] Mr Debirioun reflected on the impact this has had on the participants, who are primarily young people from South Sudanese communities:

> A lot of the time kids start making musical tracks where it's like 'I'm this, I'm that', focussing on surface level things, which is cool. But then after a while they start breaking that down and talking about everything else that's happening in their life. It becomes like a form of meditation—they get all their emotion out that they don't usually get out or they don't want to talk about.[85]

The Women's Spirit Project is another example of a community-led initiative in south-eastern Melbourne (refer to case study).

Case study:

Women's Spirit Project

The Women's Spirit Project is a volunteer-led initiative that aims to inspire and empower women facing adversities through fitness, health and wellbeing activities, and through building connections with other local women. It was established in recognition of issues facing women in the Bayside Peninsula Region in Victoria, such as social isolation, family violence, mental illness, psychological distress, unemployment and poverty.

Ms Jodie Belyea, founder of the project, said she created the program for women who, for a range of reasons, may not have been able to access fitness, health and wellbeing activities, which she believes are the cornerstones to health and healing.

> I've been working in the community, philanthropic and government sectors for 25 years and I've grown to understand there is a community of women that are really struggling. This community of women are needing supports outside of case management and counselling to help reframe their lives and give them the support to park their past for a moment—enough for them to be able to see their potential.

A pilot program for women aged 25 years or older was delivered between November 2018 and August 2019 to a group of 17 participants and 13 mentors and working group members.

Ms Belyea said the program was developed with the support of volunteers including business owners and professionals from the community, education, fitness, and health sectors.

> Everything was designed to flow from one week to another, building people's fitness but also building people's understanding of self. So, we talked about communications skills, we talked about behavioural styles and we looked at conflict resolution, because we were working as a team.

Ms Belyea said the program provided participants with the opportunity to build their mental, emotional and physical resilience and culminated in a three-day, 70 kilometre trek from Frankston to Cape Schanck.

> What I saw in the women leading up to the trek was the growing connection between everyone in the group—everyone pulling together, the participants, mentors, working group members. It was a real sense of camaraderie.

An evaluation survey conducted by Monash University showed participants found the program empowering, with the participant survey recording enhanced feelings of personal wellbeing, connectedness, self-esteem, physical self-perception and resilience.

Photo credit: Women's Spirit Project

Many of the participants reported the program was life changing. One participant said:

> It's a tough journey, but being on this track now, I feel like there's no height I cannot climb.

Ms Belyea said the design of the pilot has served as an example of collective impact, with groups from different sectors coming together to solve a specific social problem.

> What I have seen from the get-go is a project that has mobilised volunteers in the community, women from all walks of life with lots of different skills, and lots of different organisations. All getting involved to support other women and their families. For me, it's an example of driving social change from the grassroots up, not always the top down.

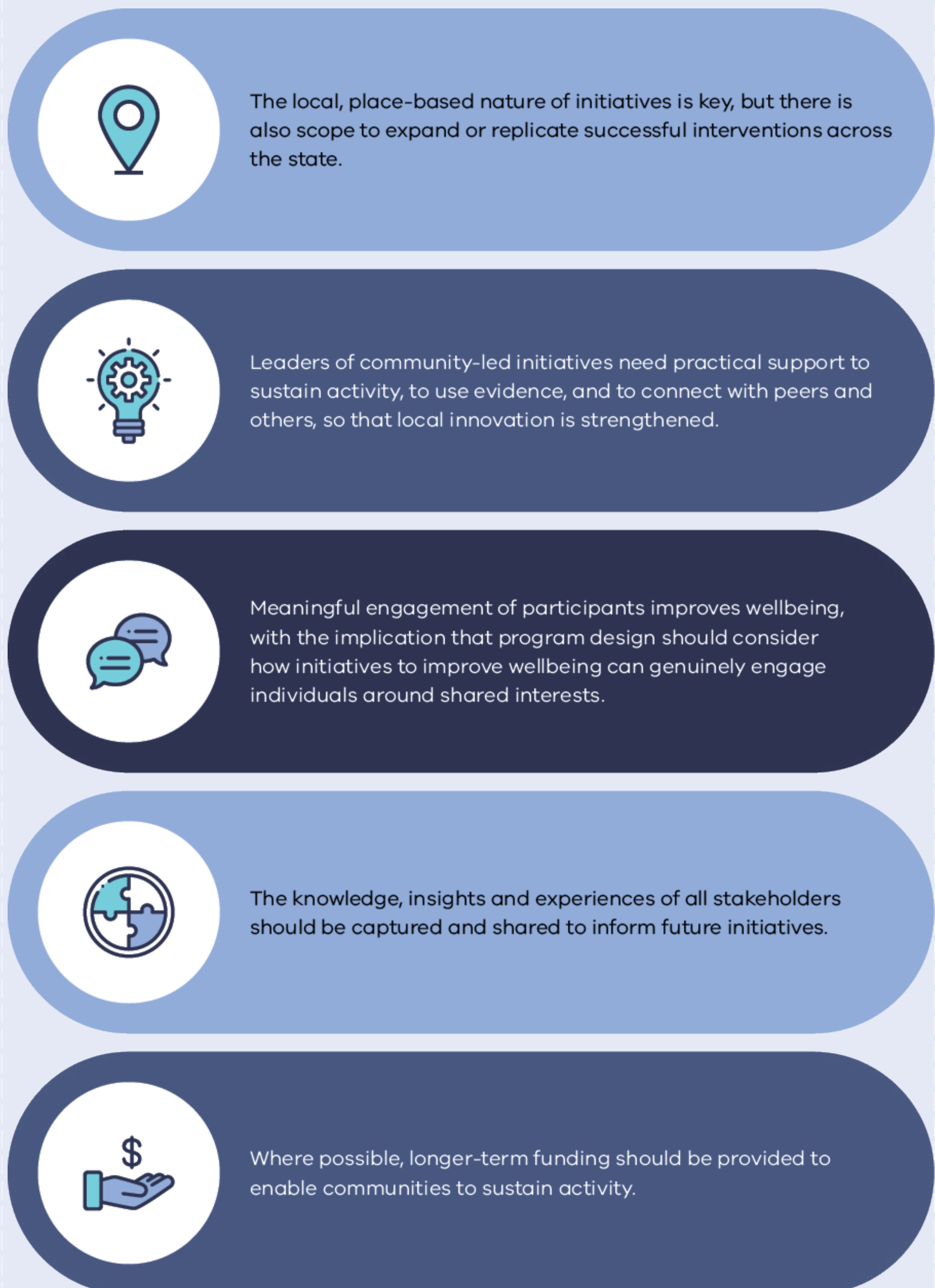
Source: Women's Spirit Project <womensspiritproject.org> [accessed 3 November 2020]; *Filling a Gap for Significant Gains: Wellbeing, Connection And Empowerment In The Pilot Program Of the Women's Spirit Project, 2019 Summary Evaluation Report*, August 2019.

There is evidence that a broad range of community activities and initiatives have the potential to positively affect mental health and wellbeing. To further inform its deliberations on this matter, the Commission engaged researchers to undertake an evidence and practice review to identify where evidence of community-led initiatives involving social connection was strongest, and to distill the common elements of successful initiatives. The review suggests that group-based exercise, support groups and intergenerational programs (that is, activities that facilitate interaction between members of younger and older age groups) demonstrated the most positive impacts on mental health and wellbeing.[86]

The common elements that were critical to the success of community-led initiatives included that they were: non-judgemental, engaging and had inclusive leadership; focused on initiatives that were meaningful for participants; and were explicitly designed to meet local, context-specific needs.[87] The review also found that formal evaluation was not common for community-led initiatives and underscored the importance of building local evaluation capacity.[88] A powerful theme that emerged from the review was the importance of strong and supported community leadership. The review highlighted governance and leadership training as areas where government could provide further support.[89]

Key themes from the evidence and practice review are outlined in Figure 11.3.

Figure 11.3: Key themes of an evidence and practice review of community-led initiatives



Source: Adapted from Peter Bragge, Alyse Lennox, Loyal Pattuwage, Alexandra Waddell and Rod Glover, *Correspondence to the RCVMHS: CSP.0001.0107.0001. The Effectiveness of Community-Led Initiatives Involving Social Connection in Supporting Mental Wellbeing: A Rapid Review of Evidence and Practice*, 2020, p. 8.

11.2.6 Local government's role in supporting good mental health and wellbeing

Local government's role in supporting community-level mental health and wellbeing efforts is well established. Prevention United's submission highlighted the potential for local council initiatives to tackle 'local-level risk and protective factors such as social cohesion, social connectedness and loneliness'.[90] In its submission to the Commission, the Municipal Association of Victoria noted that '[c]ouncils strive to facilitate inclusive communities that allow social inclusion for everyone, including people affected by mental health issues, their families, carers and friends.'[91]

Local government's responsibility for public health and wellbeing is enshrined in the *Public Health and Wellbeing Act 2008* (Vic),[92] which requires councils to develop local municipal health and wellbeing plans. These plans set the broad public health mission and local health and wellbeing priorities for each local council. Each plan is required to 'have regard to' the focus areas and priorities of the *Victorian Public Health and Wellbeing Plan*.[93]

The Municipal Association of Victoria noted that '[t]hese plans are more than high-level policy documents; they include specific actions that are achievable and measurable.'[94] It also called for more resources to support the municipal health and wellbeing plans.[95] The Corangamite Shire argued that '[l]ack of funding renders the plans as aspirational rather than genuine strategies that can drive and deliver prevention and programming in alignment with community need'.[96]

The Commission also recognises the value of local government partnering with local organisations to support mental health and wellbeing in local communities. The Live4Life case study illustrates an example of a local organisation driving change in young people's lives.

11.2.7 The Victorian Government's role in supporting community-led activity

The Victorian Government provides support for many community-level programs which aim to create the conditions for good mental health, including through strengthening opportunities for social connectedness. For example, the Victorian Government supports:

- funding for the Men's Sheds[97] and Neighbourhood Houses[98] programs
- integrated health promotion funding to a range of agencies across the state[99]
- LGBTIQ+ programs and supports, including the Pride Events and Festivals Fund,[100] and the Healthy Equal Youth (HEY) program,[101] which supports mental health promotion and community engagement activities focused on LGBTIQ+ young people
- the multicultural affairs portfolio provides a range of grants to support community harmony, multicultural festivals and events and the construction or improvement of multicultural community facilities[102]

- recent initiatives that respond to the need to support social connection in communities following the COVID-19 pandemic:
  - Let's Stay Connected fund, which provides grants for community organisations to lead initiatives that seek to combat social isolation and loneliness[103]
  - the Community Activation and Social Isolation Initiative, which helps people maintain connections with family, friends and the community by funding 'community connector' positions in local communities.[104]

The Commission is encouraged by the funding and delivery of these programs, and recognises the important role they play in supporting communities. However, it is the Commission's view that overall, government programs and grant initiatives tend to lack the flexibility required to truly harness the knowledge and capacity of communities and to support community-led responses. Community leaders who took part in the Commission's focus groups on community-led initiatives noted that where government support is available, bureaucratic processes, budget constraints and short-term funding often stifled what communities were trying to achieve.[105]

This has also been recognised by the Victorian Government. In 2020, the Department of Premier and Cabinet developed *A framework for place-based approaches*. Place-based approaches target the specific circumstances of a place and engage local people as active participants in development and implementation.[106] The framework observed that:

> **Portfolio and departmental structures mean that [government] often focus[es its] effort on one need, problem or population group at a time. Unfortunately, these top-down or centrally led approaches often miss opportunities and issues that are influenced by local contexts.**[107]

To address this issue, the Victorian Government is trialling different approaches in select communities across Victoria, including the Place-Based Suicide Prevention Trial in partnership with Primary Health Networks, as detailed in Chapter 17: *Collaboration for suicide prevention and response*.

The Commission recognises that there is often a tension between funding genuinely community-led initiatives with the lowest possible administrative burden, and the oversight and due diligence of the expenditure of public funds.[108] A strength of many community-led initiatives is the ability to respond flexibly to local need. Rigid funding criteria and burdensome reporting and acquittal requirements can constrain innovation, limit access to funding for some community groups, prevent experimentation and result in some potentially effective initiatives missing out.[109]

Witnesses reiterated the need for more government support for communities. Professor Moodie proposed that 'communities should be empowered to experiment with innovative ways of facilitating connection and inclusion,'[110] and that government can enable this through greater financial, political and community support.[111] Mr Pearl recommended that:

> **Governments can help by facilitating the facilitators. Perhaps set aside some money that you're willing to risk on a new initiative, on a new experiment. Having an experimental fund would be useful, and it would be better than declaring from the top what the desired outcome is and how to achieve it.**[112]

Case study:

Live4Life

Live4Life is a locally driven youth mental health education and suicide prevention initiative delivered by Youth Live4Life Ltd, a rurally based health promotion charity. It began in 2010 in response to a reported increase in anxiety, depression, self-harm and suicide among young people in the rural communities of the Macedon Ranges Shire.

Live4Life's objective is to reduce youth suicide by lowering barriers and increasing awareness of how to seek help. It also aims to reduce stigma, to increase the mental health knowledge of secondary school students, teachers, parents and community members and to build community resilience to address poor mental health.

The charity has expanded since it began and now works in the communities of the Macedon Range Shire, Benalla Rural City Council, Southern Grampians Shire, Glenelg Shire, Moira Shire and Baw Baw Shire. The program is delivered through a partnership approach involving local government, schools and community organisations. Youth Live4Life CEO, Mr Bernard Galbally told the Commission:

> Live4Life is a bottom-up community-driven approach. Each community is unique, so although the four key components of the model remain the same, the approach of Live4Life may differ across communities. Fidelity and longevity is key—this is not a one-size-fits-all approach.

The four components of the Live4Life model are: support, coordination and mentoring from Youth Live4Life's staff, school and community partnerships, mental health training and 'The Crew'. As part of the Live4Life model, young people are recruited as peer leaders to form 'The Crew'. They are trained and mentored to become mental health ambassadors for their schools and local communities. Local community members are also trained as mental health first aid instructors.

Ms Annie Rowland, the Live4Life Community Engagement Coordinator (North and East Victoria), said the broader community played a crucial role in the model.

> Live4Life is about building the capacity of the community in areas where the service system is lacking or failing. When a person is in crisis, the community needs to be that frontline support.

An evaluation of Live4Life in Benalla Rural City Council and Glenelg Shire indicated that the program had helped students seek mental health support for themselves or a friend. Feedback from one Year 9 students in the program included:

> I've been helping some of my friends. Yeah, there'd be less kids at school if we didn't have Live4Life.

The value of peer-led messaging about mental health was consistently confirmed through consultation with mental health workers, teachers, parents and discussions with young people. The need for reinforcement and repetition of key messages was further demonstrated through evaluation findings.

The evaluation showed that more than nine in 10 students who had been involved in Live4Life were having conversations with others about mental health since participating in the initiative.

One of the founders of Macedon Ranges Live4Life said the program aims to better resource the community to support young people.

> **We're not saying we can solve suicide. But we can try to get to those young people earlier, and build another layer, a protective layer into that community.**

Source: RCVMHS meeting with Live4Life, 11 March 2020; RCVMHS meeting with Macedon Ranges Shire Council, 2 March 2020; Live4Life, About Us <www.live4life.org.au/about-us> [accessed 10 November 2020]; *Evaluation of Live4Life in Benalla Rural City Council and Glenelg Shire Final Report,* prepared by Natasha Ludowyk; February 2020.

11.2.8 A new approach that recognises the importance of connection

The Commission's recommended approach reflects the critical importance of communities and social connection, and the Commission's view that communities are best placed to understand and drive local social connection and inclusion efforts that support mental health and wellbeing.

The Commission recommends the establishment and recurrent funding of 'community collectives' to support community-led activity that promotes social connection and inclusion. Community collectives should be established in each of the state's 79 local government areas by the end of 2022 (refer to Figure 11.4).

Community collectives will bring together community members and leaders in communities across Victoria to guide and lead local social connection and inclusion efforts. The collectives will take the lead in consulting with local communities to identify challenges and opportunities, supporting them to determine issues and take action to support the mental health and wellbeing of their communities. Each community collective will be supported by local government.

Membership of community collectives

Each collective will be made up of a broad and diverse range of community members and local leaders, determined by the community with the support of local government as auspice. Membership of the collectives should broadly reflect the community it serves, and may include younger and older community members, people from LGBTIQ+ communities, Aboriginal communities, and people from culturally diverse communities. People with lived experience of mental illness or psychological distress and their families, carers and supporters should be encouraged to participate. Figure 11.5 shows how the community collectives will bring together community members.

Local organisations will also contribute as members. These organisations may include local non-government organisations, clubs, schools, major employers and health centres and Local Mental Health and Wellbeing Services. While organisations can contribute to the collectives, the leadership and decision-making power should sit with community members. Community members should be remunerated for their time and the contribution they make to the collectives. Figure 11.6 shows the functions of the community collectives.

Grit and Resilience, established in partnership with the Rural City of Wangaratta, is a useful example of what can be achieved when the community comes together to focus on mental health and wellbeing of the community (refer to case study).

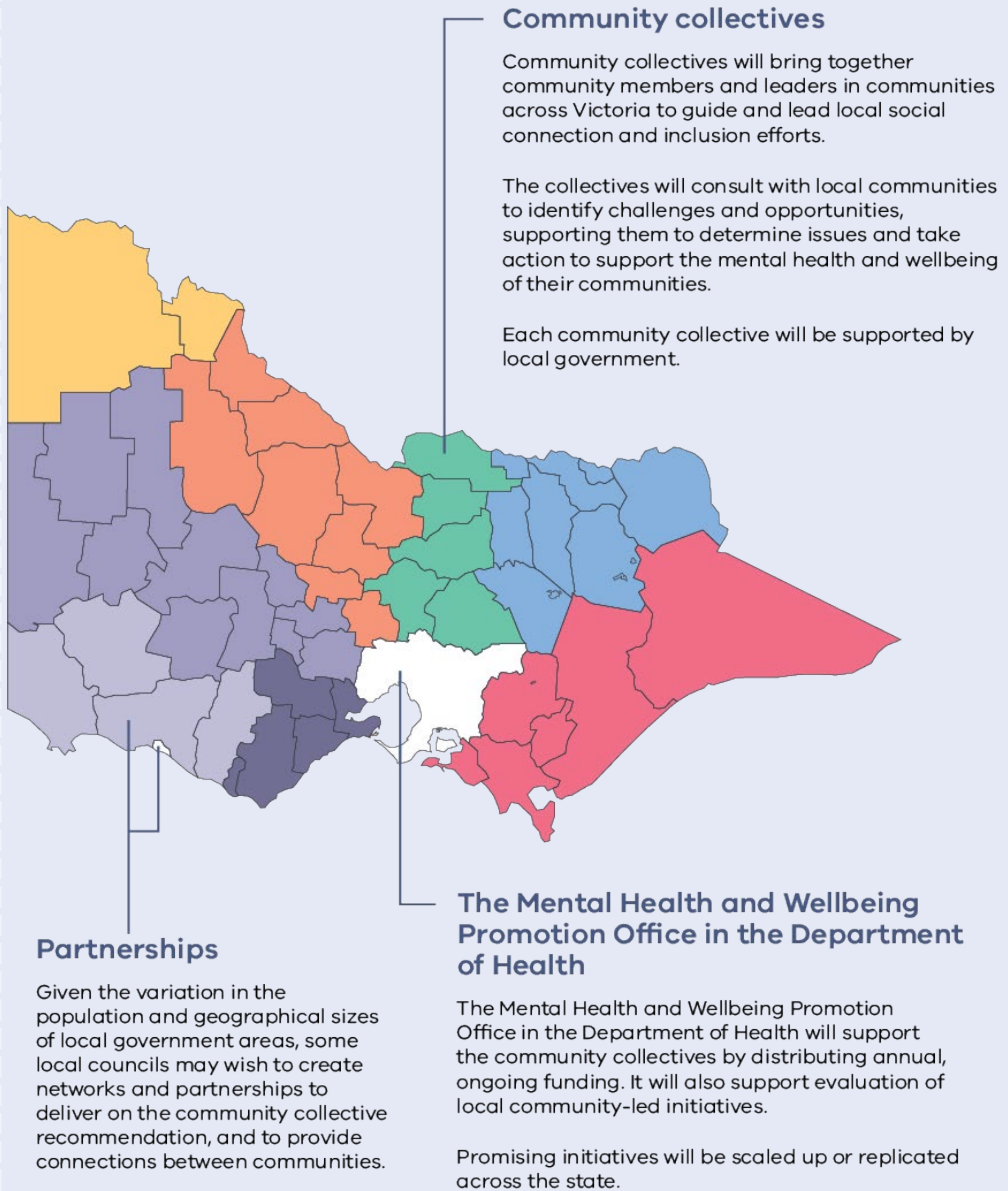


Figure 11.4: Establishment of local community collectives across Victoria

Case study:

Grit and Resilience

The Grit and Resilience program is a community-led approach, delivered by local community members in partnership with the Rural City of Wangaratta, in north-east Victoria. It aims to drive positive mental health and wellbeing in the area by supporting the local community to unite, build strength, overcome hardship, and develop courage and a connection with each other.

Ms Jaime Chubb, Director of Community Wellbeing at the Rural City of Wangaratta, said the community was the driving force behind establishing the program, in recognition of several factors posing risks to community mental health and wellbeing in the area, including youth self-harm and suicide, the effects of devastating droughts and bushfires on people's mental health, and youth disengagement from education.

> **There was a significant level of fear, confusion and uncertainty across the board—essentially, our community told us we need the tools to be able to do this for ourselves, we don't want more services, we don't want someone to come in and 'fix' it. We want to be able to look after ourselves and we want to be able to have conversations.**

Ms Bek Nash-Webster, Coordinator of the Grit and Resilience program, said the first step in establishing the program was engaging a broad range of community members to contribute to the design of the program. The priority activities the community identified were building social connection in the community, creating inclusive spaces, and supporting those bereaved by suicide.

The program is now in its second year, with almost 200 people engaged in volunteer community capacity-building activities. Representatives from the Rural City of Wangaratta, Victoria Police, the Department of Health, Albury Wodonga Health, Murray Primary Health Network, Albury Wodonga Aboriginal Health Service, Gateway Health and headspace Albury Wodonga provide support, guidance and insights to the community partners.

Ms Nash-Webster said a flexible funding model with community-led decision making was key in supporting the initiatives delivered under the program.

> **The groups have funding for whatever activities they want to do, and while we have a project logic that helps groups to map out the project and determine what they hope to see in 12 months' time, the activities they decide to do within the community is completely up to the community group that will be designing and delivering it.**

Ms Chubb noted that one example of a practical community-driven activity supported by Grit and Resilience was an idea to help young girls stay connected with sporting activities by providing gym memberships for students to help keep them active.

> We did a large youth survey and one outcome was that young girls were disengaging from sporting clubs. The high schools came to us and said, 'Can we come up with something so that we can keep them engaged and keep them active, because we know if we can get them through those last few years of high school, if they're still playing sport, their outcomes for mental health will be so much better?'.

Ms Nash-Webster said as the program had evolved, it allowed the community to be better placed to work together and support each other during times of adversity.

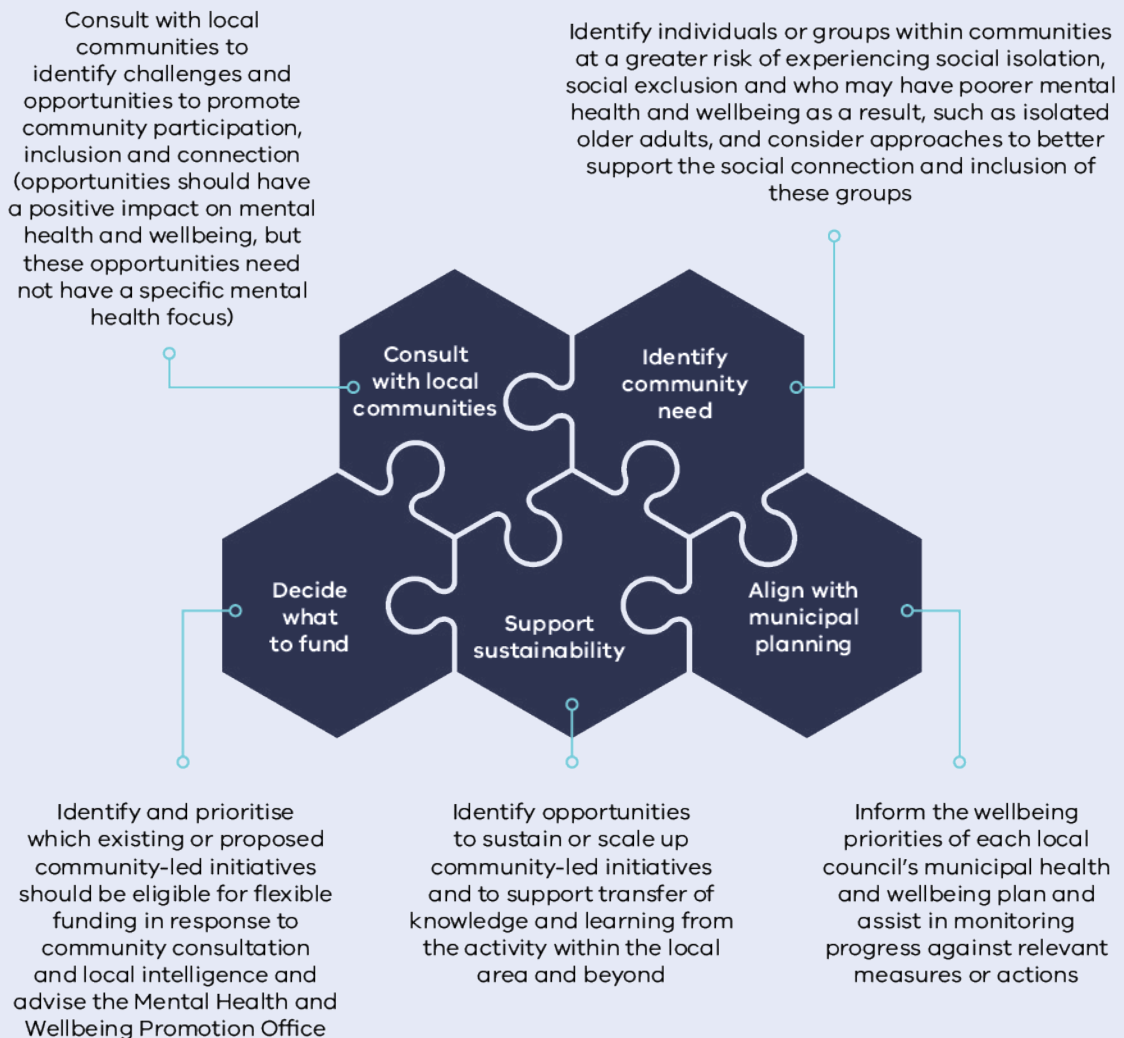
> Grit and Resilience has grown legs well beyond its beginnings. The bushfires were evidence of that—it was a demonstration of how quickly this project had embedded itself in our community. We had consortium members at the relief centre providing support, and people saw that this isn't just about delivering a service, it is about a community protecting themselves from what would be quite a traumatic event and the impacts of it.

Source: RCVMHS meeting with Rural City of Wangaratta, 15 October 2020.

Figure 11.5: Example of a local community collective

Figure 11.6: Community collectives' functions

Community collectives will be resourced and supported to test and develop a range of initiatives that promote community participation, inclusion and connection. To do so, it is expected that the community collectives will:



Identify and prioritise which existing or proposed community-led initiatives should be eligible for flexible funding in response to community consultation and local intelligence and advise the Mental Health and Wellbeing Promotion Office

Identify opportunities to sustain or scale up community-led initiatives and to support transfer of knowledge and learning from the activity within the local area and beyond

Inform the wellbeing priorities of each local council's municipal health and wellbeing plan and assist in monitoring progress against relevant measures or actions

Source: Adapted from Peter Bragge, Alyse Lennox, Loyal Pattuwage, Alexandra Waddell and Rod Glover, *Correspondence to the RCVMHS: CSP.0001.0107.0001. The Effectiveness of Community-Led Initiatives Involving Social Connection in Supporting Mental Wellbeing: A Rapid Review of Evidence and Practice,* 2020, p. 6.

Funding allocation and the role of the Mental Health and Wellbeing Promotion Office

The new Mental Health and Wellbeing Promotion Office located within the Mental Health and Wellbeing Division of the Department of Health, as detailed in Chapter 4: *Working together to support good mental health and wellbeing,* will provide coordination and oversight of the community collectives. It will distribute annual, ongoing funding to support one fulltime-equivalent staff member in each local government area to act as a support for the community collectives. Additional flexible funding should be provided to enable the community collectives to undertake their functions, including distributing funding to support local community activities.

In determining the distribution and amount of funding, the Mental Health and Wellbeing Promotion Office should consider the population size of the local government area and the extent of community need and readiness, informed by relevant health and wellbeing indicators and local intelligence.

By way of comparison, the 2018 *Pick My Project* community grants initiative had a total funding amount of $30 million for Victoria for one year, which was the funding pool available to support local activity and did not include staffing support for each local government area.

To illustrate, in any one local government area, the following types of activities might be funded:

- a local community garden project, promoting connection within the neighbourhood
- a seniors' community art initiative, combating social isolation
- leadership training to enable an innovative community-led initiative to expand
- the development of a series of inclusive community events in a local community hub.

Public flexible funding guidelines will be developed by the Mental Health and Wellbeing Promotion Office, in collaboration with the collectives and local government. Each of the 79 local government areas should receive annual flexible funding to support the provision of local grants. While the local council acts as an auspice for the collectives, the collectives will ultimately determine distribution of that funding to the local community.

The Mental Health and Wellbeing Promotion Office may provide other forms of assistance or resources to enable the collectives to create and sustain community activity, in line with its communications, workforce development and research functions. It will also provide evaluation support for local funded initiatives to build the evidence base. The Mental Health and Wellbeing Promotion Office and local councils should assist the community collectives by collating and interpreting available datasets to provide a better understanding of each community.

The role of local government

The Commission recognises that a local auspice is a critical feature to support local community mobilisation initiatives. It is recommended that local government in each community plays this role. As auspice, local government will provide support and coordination, and administer funds on behalf of the community collective. There are good examples across Victoria of local councils playing an active role in facilitating community involvement, as reflected in case studies in this chapter, and huge potential to build on existing local government practice. Therefore, the Victorian Government will fund each local government to recruit one fulltime-equivalent staff member at the program manager or coordinator level to support the community collectives.

Given the variation in the population and geographical sizes of local government areas, some local councils may wish to create networks and partnerships to deliver the community collective recommendation, and to provide connections between communities.

The Commission understands that some local councils may already be delivering initiatives that align with this recommendation. In those instances, resources provided may build on existing local government initiatives that are consistent with the community collectives as described in this section.

Development of local digital directories

To build knowledge and awareness of existing local community initiatives that support social connection and inclusion, the Commission considers that the Victorian Government should support the Municipal Association to oversee the development of user-centric and accessible local digital community directories. These will be co-designed with local community members, including older and younger people and community members whose first or preferred language is not English, to ensure the directories are accessible and meet the needs of the community. The directories will advertise local community initiatives to be used by local community members and the new collectives, as well as by Local Mental Health and Wellbeing Services for initiatives such as social prescribing. These directories will be established in each local government across Victoria and maintained by local councils. Local councils that have already established a similar function may share implementation experience with the Municipal Association of Victoria and should review their community directory to ensure that it is as accessible as possible.

Social prescribing trials

Recognising that the evidence base for social prescribing is emerging, the Commission recommends that the Victorian Government establish one social prescribing trial per region in Local Mental Health and Wellbeing Services by the end of 2022. These trials will support healthcare professionals to refer people with lived experience into non-clinical community groups and supports. This will test social prescribing as a model to strengthen pathways between Local Mental Health and Wellbeing Services to initiatives that support community participation, inclusion and connection. Bearing in mind the evidence before the Commission about the harmful impacts of isolation and loneliness on the mental health of older Victorians, it is recommended that isolated older people are a priority group for the social prescribing trials.

The three-year trials will be overseen by the Department of Health, and the outcomes assessed to determine whether further roll-out is warranted. The trials will consider models of social prescribing which have been tried and tested and which have demonstrated efficacy and evidence of success. In initiatives in other countries, for example, a 'link worker' role helps consumers establish connection and begin participating in community activities.[113] This role was considered central to these social prescribing initiatives, and was undertaken by a practice nurse or receptionist in those examples.[114] The Royal Australian College of General Practitioners stated that further analysis is needed to determine which professions are best placed to fulfil the 'link worker' role in Australia.[115] The Commission notes that this function may be carried out by a worker who will form part of the Local Mental Health and Wellbeing Services, including a peer worker. The trial will test models of connecting to community through a 'link worker', and the skillset that is required for this role.

To oversee the trial, a steering committee will be established. Membership should comprise consumers, mental health professionals, local government, and members of the community collectives. The trials will be rigorously evaluated using an evaluation framework that is sensitive to local contexts. The outcomes will be considered by the Chief Officer for Mental Health and Wellbeing as they relate to mental health promotion and also service design and delivery. Subject to the outcomes of the trials, a framework for broader implementation may be established.

Community collectives will play an important role in supporting social prescribing trials. The establishment of digital directories, as described earlier, will help the social prescribing trials identify initiatives in local areas. Local governments can assist by providing the venues, programs and partnerships needed to deliver activities in settings like the arts, sports and community centres.

11.3 Mentally healthy workplaces

Work is a critical enabler of mental health and wellbeing.[116] Work provides purpose, contributes to our sense of identity, and facilitates social connection and economic participation, each of which promote and support mental wellbeing.[117] Employment is also recognised as a key protective factor for mental health and is associated with an improved quality of life.[118] Ms Georgie Harman, CEO of Beyond Blue told the Commission:

> **Good work is really good for our mental health. It not only pays the bills but it also gives us a sense of meaning, a sense of purpose and a sense that we're contributing something, and every day in workplaces around Australia, there are people who are living and working extremely effectively and productively with mental health conditions ...**[119]

The Commission recognises the potential of workplaces to reach a significant proportion and a broad cross-section of the Victorian community. In its submission to the Commission, Beyond Blue emphasised that 'intervening in the big settings where people live their lives—at work and in education—creates scope for population-wide, transformational, cost-effective change'.[120] The World Health Organization echoes this sentiment, identifying workplaces as a key setting to promote mental health.[121] In Chapter 4: *Working together to support good mental health and wellbeing*, the Commission identifies workplaces as a priority setting to support good mental health, and, as outlined in section 11.3.1, a key source of support for people with lived experience of mental illness or psychological distress.

The Commission envisages a future in which all Victorian workplaces play a positive role in promoting mental health and wellbeing for all employees, volunteers and the wider community. In this vision, workplaces of many sectors and sizes are supported to promote positive mental health and wellbeing, prevent mental injury and support people with lived experience—and they have the guidance and resources to excel at this. The Commission acknowledges that workplaces are employers and businesses in the first instance, with many competing demands and responsibilities. The reforms outlined in this chapter have been designed to support businesses and employers to deliver mentally healthy workplaces as part of their day-to-day operations, through the establishment of statewide leadership, tailored guidance and resources, and the development of stronger evidence to guide practice. The primary purpose of these reforms is to support mental health and wellbeing outcomes for Victorians. However, recognising that good mental health and wellbeing is also good for business, these efforts are also expected to deliver benefits for workplaces and the Victorian economy.[122]

The reforms described in this chapter seek to build on the goodwill and commitment the Commission witnessed from many employers across the state,[123] and to provide the foundations for businesses to support their employees. The recommended reforms will make it easier to find information and access tools and resources tailored to industries and sectors, and will ensure that support for small business is available as a priority. These reforms require cross-sector leadership and provide a mechanism for government, employers, employees, unions and non-government organisations to work together to identify what works and to promote mental health and wellbeing in Victorian workplaces.

Mentally healthy workplace trials, carried out in a range of industries across the state, will test and trial evidence-informed strategies to improve understanding about what works to promote mental health in industries and sectors where workers are at higher risk of mental injury, or have been disproportionately affected by COVID-19 restrictions.

As a result of these reforms, employees who experience poor mental health, or who are carers of someone with lived experience of mental illness, will be better supported and better understood.

11.3.1 The relationship between work and mental health

Evidence indicates that the relationship between work and mental health is bi-directional. While having a job is generally good for physical and mental health,[124] workplace stress and stressors can cause psychological distress or mental injury.[125] Furthermore, unemployment is recognised as having a 'significant negative effect on mental health and wellbeing'.[126]

Work as a protective factor

Dr Michelle Blanchard, Deputy CEO of SANE Australia and Founding Director of the Anne Deveson Research Centre, told the Commission:

> Participation in meaningful work can promote mental health. By providing people with purpose, financial independence, connectedness and a better standard of living, employment can support both physical and mental health.[127]

Evidence indicates that being employed is linked to a greater sense of autonomy, improved sense of wellbeing, reduction in symptoms of depression and anxiety and opportunities for personal development.[128] Employment is an important means of obtaining financial resources, which support material wellbeing, such as safe and stable housing, food and medical support.[129]

Work also offers hope, which is a critical enabler for people living with mental illness or psychological distress to live a 'contributing life'.[130] A Victorian Parliamentary *Inquiry into Workforce Participation by People with Mental Illness* found '[h]aving a job is often just as important to recovery as secure housing and is important for social inclusion'.[131] For people experiencing mental illness with complex support needs, work is associated with improved self-esteem, better wellbeing, more social contact and independence and the reduced use of community mental health services.[132] Mr Daniel Bolger, a young person with lived experience of mental illness, shared with the Commission his experiences of reconnecting into the community and finding work following his release from Malmsbury Youth Justice Centre:

> After serving 12 months I was released in 2014 and played senior football for 2 years. The first year was going well. I was working full time. I was playing football. I was hanging out with new mates and I had a lot of positive people in my life. I felt accepted.[133]

The culture and organisational practices of a workplace are important for mental health. Research conducted by the Diversity Council Australia indicates that inclusion is strongly linked to mentally healthy and psychologically safe workplaces.[134] Mr Colin Radford, CEO of the Victorian WorkCover Authority, told the Commission that inclusion and being valued are the most important aspects of a mentally healthy workplace:[135]

> **Employees who feel equally valued for who they are, as for what they do, will generally contribute to a positive and inclusive workplace culture. Respecting and celebrating diversity in all of its forms, including diversity of thought, and recognising and addressing intersectionality in eliminating discrimination and promoting inclusiveness are also critical.**[136]

Ms Lisa Annese, CEO of the Diversity Council Australia, explained that the skills of inclusive leadership are not necessarily innate; they are learned:

> **individuals have to learn how to be an inclusive employer, manager or leader. Most people have to learn the requisite skills because we are actually not programmed to be comfortable with difference, we are programmed to be comfortable with things that are very similar to us.**[137]

Ms Annese told the Commission that diversity is good for business because it leads to better workplace cultures, higher levels of productivity, better problem solving and better creativity.[138]

When work becomes a risk factor

Evidence to the Commission indicates that the number of mental health injury claims is rising in Victoria.[139] WorkSafe, the regulator of Victoria's occupational health and safety laws and administrator of Victoria's workers compensation scheme,[140] estimates that 'mental injury claims are expected to increase by at least 34 per cent by 2030, compared with 12 per cent for physical injuries'.[141] These estimates were made prior to the COVID-19 pandemic.

Evidence indicates there are risk factors in workplaces that contribute to psychological distress and mental injury.[142] Figure 11.7 categorises workplace mental health risk factors across five domains: structural and organisational factors; team and group factors; job design; individual factors or characteristics, and; conflict in demands between home and work.[143]

In its Consensus Statement, the Prevention Coalition highlighted racism and discrimination as workplace risk factors for mental health.[144] Ms Hosch told the Commission that 'racism and all forms of discrimination have a huge part to play in mental health and wellbeing.'[145] Ms Hosch observed that a lack of open conversation about racism and its impacts on mental health is part of the problem:

> **There is a complete and utter lack of recognition, conversation and leadership around the mental health impact of discrimination in the lives of people who experience it. This is deeply concerning.**[146]

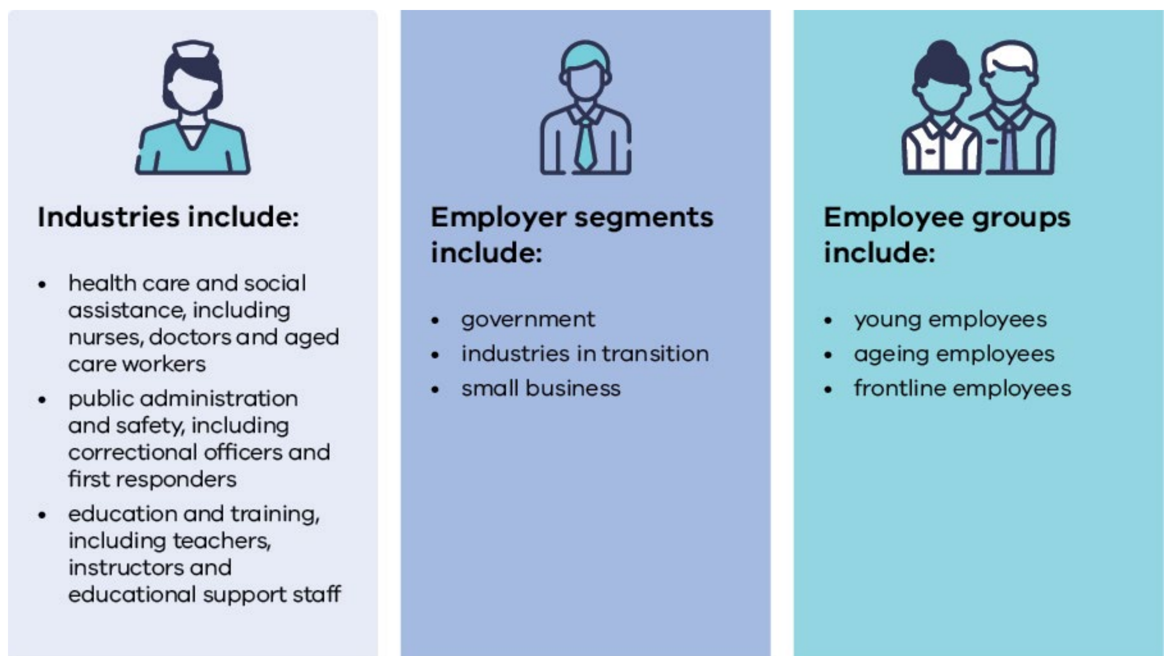
Figure 11.7: Workplace risk factors for poor mental health

Sources: Adapted from Prevention Coalition in Mental Health, *Primed for Prevention: A Consensus Statement on the Prevention of Mental Disorders,* 2020, p. 37; Dr Samuel B Harvey and others, *Developing a Mentally Healthy Workplace: A Review of the Literature,* 2014, p. 5.

Mr Radford observed that 'risks to mental health are present in almost every workplace and employees are often exposed to a combination of psychosocial hazards'.[147] The mutually reinforcing nature of workplace risk factors, individual characteristics and home and life pressures provides a level of complexity when considering approaches to supporting mental health at work. Unlike many physical health occupational risks, where only a small number of people may be exposed, or where the hazards are more visible or can be physically removed or altered, 'all working people' can be potentially exposed to job stressors; this means that even small increases in risk from such exposures can translate to substantial—and yet preventable—illness burdens.[148]

The breadth of workplace risk factors for mental health means that exposure is possible regardless of industry or work type.[149] However, WorkSafe Victoria has found that some industries, sectors and employee groups, described in Figure 11.8, are over-represented in mental health injury claims, indicating a higher exposure to risk factors.[150] Furthermore, the Commission recognises that some industries are more likely to be exposed to potentially traumatic events. This is discussed further in Chapter 15: *Responding to trauma*. In implementing the reforms described in this chapter, the Victorian Government should prioritise these industries and employer segments, together with those industries considered hardest hit by COVID-19 restrictions.

Figure 11.8: Industries, sectors and employee groups at higher risk of mental injury



Source: *Witness Statement of Colin Radford*, 26 August 2020, para. 53.

Personal story:

Maria Katsonis

Maria experienced a major depressive episode that led to a life-threatening mental health breakdown. She sought help from a GP, who referred her to a psychiatrist. She was admitted to a mental health facility and told she would be staying for a week.

As an executive in a public sector organisation, Maria informed her CEO about her illness and the expected length of her hospital stay. However, she ended up spending five weeks in hospital, and it was another four weeks before she was able to return to work.

Maria's experience returning to work proved to be challenging.

> No one prepared me to return to work and I didn't prepare myself. I was discharged with only an appointment to see a psychiatrist. There wasn't any discussion of community mental health programs that could have helped me ease back into it. I had no prior experience with the mental health system and I didn't know what support was available and what to ask for.

Maria felt that her workplace was also not prepared for her return to work.

> I initially didn't have a return to work plan. If I'd been in the equivalent of a car accident with half my body in a plaster cast, my first day back would have been a very different proposition. It was partly due to the invisibility of mental illness. Out of sight, out of mind. The organisation also had limited experience in dealing with a major mental health workplace issue.

Wanting to be open about her experience of mental illness, Maria decided to tell her colleagues about her depression. She was met with an incredibly positive response, with 'people starting to share with me their own experiences with mental illness'.

As a result, she decided to write an op-ed for a newspaper about the stigma of mental illness. Colleagues advised her not to write the article because they thought it could adversely affect her career. The article was published and it led her to becoming involved with peer support and advocacy. This became a key component of Maria's recovery and she co-founded a sector-wide peer network as well as joining mental health advocacy bodies.

Maria highlights the crucial role the workplace plays in promoting positive mental health and wellbeing.

> Work is fundamental to recovery from mental illness. It restores purpose, self-esteem and identity—everything your illness takes away from you.

> But it's more than recovery, especially when you have a chronic mental illness like me. How can a workplace support me to stay at work so I can be productive and make a positive contribution? A supportive workplace values people with mental illness and treats them equally without fear of discrimination and stigma. Otherwise you are always wondering, is [it] okay to tell my manager about my illness? Will I be judged? Will I be stereotyped?

For Maria, having workplaces that are inclusive and stigma-free comes down to leadership and creating a culture where mental health issues can be openly discussed.

> Policies and programs on their own are not enough. They need to be championed at senior levels. It's also essential to include the voice of lived experience in the workplace—in policy development, program delivery or other mental health decision-making forums. As we say in the lived experience community: *nothing about us without us*.

Source: RCVMHS, *Interview with Maria Katsonis*, July 2020.

The World Health Organization summarised the consequences of poor mental health in the workplace as follows:

- absenteeism—an 'increase in overall sickness absence, particularly frequent, short periods of absence'[151]
- reduced productivity and output, including increased rate of error, accidents, poor decision making and a deterioration in planning and control of work[152]
- changes in staff attitude and behaviour, for example, decreased motivation, poor timekeeping and staff turnover[153]
- tension and conflict including between colleagues, with clients and an increase in disciplinary measures needing to be drawn on.[154]

Insecure work and unemployment

Insecure work and unemployment are risk factors for poor mental health.[155] For insecure work, which is defined as casual and permanent irregular work, key factors include perceived job insecurity, lack of control over scheduling and hours worked or being unable to refuse work when offered for financial reasons.[156]

Research indicates that although some workers enjoy the freedom and flexibility that casual work offers,[157] those same workers are typically less likely to report being reliant on the income gained from the casual job, generally using it to top up other sources of earnings.[158]

A lack of access to paid sick leave, carers leave and recreational or annual leave can also limit people's ability to access mental health treatment, care and support. Research indicates that people ignore or minimise health needs or go to work when experiencing mental illness because they could not afford time off work.[159] The Commission is aware of the Victorian Government's announcement in November 2020 of a Secure Work Pilot Scheme, which will provide up to five days of sick and carer's pay at the national minimum wage for casual or insecure workers in priority industries.[160]

Evidence indicates a strong, inverse relationship between unemployment and mental health;[161] job loss reduces mental health and re-employment improves it.[162] Unemployment is associated with a decline in standard of living, insecurity of income, increased stigma and loss of self-esteem and reduced social engagement, each of which affects mental health and wellbeing.[163]

People with lived experience of mental illness or psychological distress who have complex support needs are more likely than the general population to experience longer periods of unemployment.[164] People with more common mental illnesses also find it more difficult to maintain employment than the general population.[165] They can often gain employment, but they are more likely to cycle in and out of work. [166]

Barriers to work for people with mental illness or psychological distress

Witnesses before the Commission described how important work and volunteering is for people with lived experience of mental illness.[167] Mind Australia quoted one person as stating:

> I just want to work. I liked getting up and having something to do. I didn't think so much. I wasn't alone in my head so much.[168]

However, the Commission has heard that 'not all employers understand how to best manage and accommodate mental illness and psychological distress within workplaces'.[169]

Many people with lived experience face stigma and discrimination in disclosing their mental illness or psychological distress to their employer or colleagues.[170] The Commission has heard that people are concerned that disclosing their mental illness or psychological distress to their employer or colleagues would lead to them being labelled as less capable, negatively impacting opportunities for career progression.[171] In its submission, Beyond Blue shared the experiences of one of its survey respondents with the Commission:

> Workplaces treat you differently. I am passed over for opportunities because I might not be able to handle extra stress ... Co-workers see you as less competent or attention seeking. It's better not to ask for assistance because work tends to make a big issue.[172]

These concerns are not unfounded. Figure 11.9 shows some of the barriers people with lived experience of mental illness or psychological distress face when at work or in looking for work. Research indicates that there are systemic discriminatory workplace practices towards people with lived experience of mental illness based on beliefs that they lack competence, need supervision or that work is not healthy for them.[173]

The Victorian Equal Opportunity and Human Rights Commissioner, Ms Kristen Hilton, told the Commission that 35 per cent of mental health discrimination complaints relate to employment,[174] with many complaints relating to employers not making reasonable adjustments for people who disclose their mental illness,[175] despite obligations to do so.[176]

Ms Annese told the Commission that there are many 'invisible' ways workplaces can discriminate against people with lived experience of mental illness:

> Outright discrimination can also be a barrier to the employment of people with mental illness. However, there are also other more invisible ways in which we organise work that can act as barriers. The way that work is structured and organised, and the ability of employers to understand difference, can be both enablers or barriers depending on the workplace.[177]

Ms Harman told the Commission that industry and workplaces need to create opportunities for, and reduce discrimination against, people with experience of mental illness who require high-intensity supports, because such people make valuable contributions to workplaces.[178]

Figure 11.9: People with lived experience of mental illness face barriers to work and employment

When people do disclose they have a mental illness, there can be serious consequences. They can be 'time-capsuled' by their employer and colleagues as though their mental illness defines them and their state of their mind at the time they disclose is something that will dictate their ability forever. Which is not true.[1]

The *State of Workplace Mental Health in Australia* found that 30 per cent of respondents believed a co-worker with depression or anxiety would be 'unpredictable at work', 32 per cent would 'prefer they were not their line manager' and 31 per cent believed 'they were unlikely to perform their job adequately'.[2]

I've been to employment agencies where I had a woman ask me "why haven't you worked in the last few years?" and when I told her I had depression and anxiety she said "You look fine, you need to get over it". The next consultant put me in a role that didn't fit my skills or location and when I told the manager he told me that they couldn't help me because I was too hard to deal with.[3]

My daughter went to Centrelink and at the end of her appointment they said we'll try to find you a job but just don't tell anybody you're schizophrenic.[4]

Sources: 1. Joint *Witness Statement of Lisa Annese and David Morrison AO*, 14 July 2020, para. 26; 2. TNS Global and Beyondblue, p. 7; 3. RCVMHS, *Melbourne Community Consultation, May 2019; 4.* RCVMHS, *Melbourne Community Consultation, May 2019.*

Families, carers and supporters of people with lived experience of mental illness or psychological distress also experience challenges in accessing employment. One in five carers give up work to care for someone.[179] Only 56 per cent of primary carers are in the workforce compared with 80 per cent of non-carers.[180] Furthermore, the stigma often experienced by people with cognitive impairment and/or mental illness can also be felt by their carers.[181] The *Victorian Carer Strategy 2018–2022* noted that carers can experience discrimination in accessing employment because of their care role.[182] Carers Victoria recommended employer education on understanding mental illness and implementing flexible employment practices to accommodate the particular needs of mental health carers.[183]

The challenge of returning to work

Returning to work following a period of mental illness is often a challenging time. Teresa, a witness, told the Commission of the challenges she faced in returning to work following time spent in a hospital:

> **If I had taken sick leave at work because of physical illness like breast cancer, everyone would be sending me flowers and could easily name the problem. However, when it comes to mental illness, I have the impression that people are unsure what to do. People seem to be hypersensitive about mental illness. It is not spoken about openly. It's ok to be unwell. But we aren't sure if it's acceptable to be mentally unwell. There seems to be a fear about naming mental health problems. I had never heard anyone at my workplace say that they have spent time in a psychiatric hospital. When a person disappears for a time and then returns on a special project, it is only talked about quietly. When I was the one experiencing this, it felt really lonely'.[184]**

The Productivity Commission noted that returning to work is typically 'more problematic for those with a work-related mental health condition or psychological injury than for other injuries.'[185] The National Return to Work Survey 2018 showed that workers with a mental health condition 'were significantly less likely to report receiving positive support from their employer'.[186] Research describes growing recognition from employers that return to work strategies for people with mental illness are likely to need to be significantly different from those used to accommodate workers with physical conditions.[187]

Mr Radford told the Commission that 'it is clear that workers with a mental injury are having challenging experiences in the compensation and recovery system which was designed and established primarily to deal with physical injuries'.[188]

The Commission supports the recent introduction of legislation by the Victorian Government which provides Victorian workers who seek compensation for a mental health injury under WorkCover 'payments to cover reasonable medical expenses while they await the outcome of their claim'.[189] The Commission supports the legislation's inclusion of eligible volunteers, including 'Emergency Management Victoria volunteers, volunteer school workers and jurors'.[190] This scheme aligns with the Productivity Commission's findings that early intervention and access to treatment is critical to enable early return to work for workers with a psychological injury or mental illness,[191] and its recommendation that workers compensation schemes be amended to provide and fund clinical treatment, regardless of liability.[192]

Jen Riley shared her experience of returning to work and how the support she received from her employer was an essential part of her own recovery journey (refer to personal story).

Personal story:

Jen Riley

Working overseas as part of a youth ambassador program when she was in her early twenties, Jen contracted dengue fever. This was the start of many years of living with health problems, including being very unwell with chronic fatigue, which had a significant impact on her mental health and wellbeing.

> I just felt so alone and frightened about what it all meant for the rest of my life. I was ashamed and embarrassed about my condition.

Initially, Jen was told that she would not be able to work for up to 12 months, so she arranged to take leave from her job with the Commonwealth Government.

She started working with a mental health team, including a psychologist and an occupational therapist to support her recovery.

> I found a psychologist with a sport psychology background who understood high-performing personalities like mine. She really got 'me' and was able to work with me to accept what was happening.
>
> Finding the right treatment team was a life raft. I had been trying to marshal my own resources to find solutions, but they helped me make sense of it.

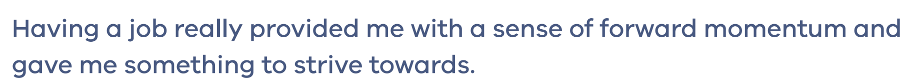
When she was ready to go back to work, Jen's psychologist recommended she stagger her return in shorter stints at first and work two or three hours a day, twice a week.

In consultation with her manager, Jen's workplace identified a team and a project that matched her skills and availability and planned for her return. Jen said she felt anxious about going back to work but received great support from her manager.

> My workplace was so supportive it was amazing. We developed a work plan and a project that suited my skills and availability. I never felt as though I was being pushed harder than I could perform. They could see I was really trying, even though my illness wasn't particularly visible.

As her recovery progressed, Jen felt well enough to start working more hours and incorporated regular breaks into her day. Her workplace supported this adjustment until she was well enough to gradually return to working full time again.

> It meant everything to be able to work at a pace that suited my recovery. It meant I could participate in conversations with friends about work, just like everyone else.



> Having a job really provided me with a sense of forward momentum and gave me something to strive towards.

Jen said that the coordinated support she received to return to work was an essential part of her own recovery journey. She said that being able to work while she was recovering was incredibly valuable and helped her own sense of dignity and identity.

> I do believe that without the work component, I don't think I would have recovered. It just anchored me during a time of life that I could have derailed.
>
> If I didn't have that, I would have just been lost at sea—like what's the point? I had some really dark moments, but the job gave me hope that I could get back to a normal life. That I could be engaged and productive and use my intelligence and everything I've worked for.

Source: RCVMHS, *Interview with Jen Riley*, November 2020.

11.3.2 Supporting mental health while improving business

The impacts of poor mental health on business are significant and should be a powerful incentive for businesses to take action to support the mental health of employees.[193] Evidence to the Commission indicates that mental illness is one of the leading causes of long-term sickness absence and long-term work incapacity among Australian workers and has major costs for individuals, their employers and society more broadly.[194]

Annual estimates of the financial impact of mental illness on Australian workplaces are increasing, from approximately $11 billion in 2014[195] to $12.8 billion in 2015–16.[196] In June 2020, the Productivity Commission estimated that 'absenteeism and presenteeism in the workforce costs up to $17 billion per year'.[197]

Safe Work Australia reported that each year:

- '7,200 Australians are compensated for work-related mental illnesses, equating to roughly 6 per cent of workers compensation claims
- 60 per cent of mental disorder claims are awarded to workers who are 40 years old and over
- approximately $543 million is paid in workers compensation for work-related mental illnesses
- workers with severe depression take, on average, 20 times more sick days per month compared with the rest of the workforce'.[198]

Absenteeism (time off work) and presenteeism (reduced productivity at work), staff turnover and higher workers compensation due to mental illness incur significant costs to business.[199] The Organisation for Economic Co-operation and Development report, *Sick on the Job? Myths and Realities about Mental Health and Work* found that workers with mental illness are absent from work for health reasons more often than other workers (32 per cent versus 19 per cent).[200] They are also typically away for longer (six days compared with 4.8 days of absence).[201] It also found that 74 per cent of all workers with mental illness had reported reduced productivity at work in the previous four weeks, compared with only 26 per cent of workers without a mental health diagnosis.[202]

The Productivity Commission estimates that 36 per cent of workers with mild to moderate mental illness and 56 per cent of workers with severe mental illness report having trouble doing their job properly due to their health problems.[203] People are more likely to leave the workforce when their mental health declines.[204] The subsequent costs of staff turnover in hiring and training someone new can be expensive to business.[205]

The economic benefits of mentally healthy workplaces

The term 'mentally healthy workplace' has gained traction across workplaces and government. It describes a workplace where mental health risk factors are acknowledged, action is taken to minimise their impact, and protective factors are fostered.[206] The Commission supports the use of this term because it differentiates factors which impact mental health and wellbeing from physical health and safety, and provides a framework and a language for employers and employees to engage with and act on.

Mentally healthy workplaces typically have systems in place that can identify the early signs of employees experiencing a decline in mental health and needing support. Managers are trained and confident to have a conversation with employees and make the necessary adjustments to support their wellbeing. Employees are also encouraged and supported to ask for help, which can mean that their mental health is better managed earlier. Evidence indicates that effective action to create a mentally healthy workplace is a good investment for business. PricewaterhouseCoopers calculated that, on average, the return on investment for all industries and actions investing in a mental health initiative in the workplace is 2.3.[207] That is, 'for every dollar spent on successfully implementing an appropriate action, there is on average $2.30 in benefits to be gained by the organisation'.[208] Return on investment was assessed as being 'where presenteeism, absenteeism and workers' compensation claims are reduced by 33 per cent'.[209] On average, where claims were reduced by 33 per cent:

- 'a person experiencing a mild mental health condition will experience 10 more productive hours per year
- a person with a moderate mental health condition will experience two fewer days absent and spend seven working days (52.5 hours) more time being productive at work per year
- a person with a severe mental health condition will experience over 13 fewer days absent and spend almost 17 working days (127.5 hours) more time being productive at work per year'.[210]

PricewaterhouseCoopers noted that the return on investment calculation is based on a single action to support mental health in the workplace, but if an organisation implements more than one action, further benefits are likely to be achieved.[211]

The *State of Workplace Mental Health in Australia* report (2014) found in workplaces that employees considered to be 'mentally healthy', 'self-reported absenteeism as a result of experiencing mental ill-health almost halves'.[212]

The COVID-19 pandemic has brought the link between mental health and work to the fore. Ms Christine Morgan, CEO of the National Mental Health Commission, told the Commission:

> Because of the pandemic's near-universal impact, advice about how employers and workers can manage the psychological issues associated with changed work conditions (including job loss) is very widespread. The forms of isolation required in the current period can be a risk factor for some mental health conditions, as well as the trauma and workplace stress being experienced by frontline workers in health and emergency services.[213]

The COVID-19 pandemic has also reshaped the way people think about work and the 'workplace'. [214] The pandemic has disrupted the notion of the 'office', demanded significant increases in flexible working and accelerated the use of technology to stay connected.[215] While this disruption has brought some benefits, it has also brought new risks to mental health.[216]

WorkSafe predicts that increasing numbers of people working from home may lead to more people feeling isolated from colleagues, unclear about their role, not valued for the work they do and less supported.[217] People may also find it hard to separate their work responsibilities from their home lives and responsibilities.[218] In delivering the reforms described in this chapter, the Victorian Government must give due consideration to what a mentally healthy workplace is in the context of COVID-19, and what it means to promote mental health and wellbeing, where new working from home arrangements may become more common.

Change-ready workplace leaders

The Commission has been impressed by the goodwill and efforts of many workplaces to support mental health and wellbeing, and recognises significant efforts underway in businesses and workplaces across the state. Ms Morgan told the Commission that:

> Australia is on the cusp of significant change in the workplace mental health area. There is more awareness of the issue, and Employee Assistance Programs (EAPs) are reporting increased usage with workplace issues now the single most common reason people give for approaching an EAP. Focus is shifting from the reactive management of sickness absence, to a more proactive effort around employee engagement and preventative initiatives. This is especially evident in large organisations where corporate leaders are implementing impressive corporation-wide policies and initiatives.[219]

As part of its engagement process, the Commission held a Mentally Healthy Workplaces Roundtable that was attended by senior leaders from a broad range of large, medium and small businesses. Participants shared many examples of strategies and programs being implemented by organisations to improve mental health in the workplace and described a renewed focus on these efforts in the context of COVID-19.[220] Findings from the roundtable reflected other evidence before the Commission describing a strong level of readiness and willingness from Victorian workplaces to take a lead in supporting the mental health and wellbeing of Victorians.[221] The sections below outline some of the key supports business representatives, witnesses and evidence before the Commission pointed to, to enable organisations to deliver initiatives with the best possible chance of success.

Guidance, resources and evidence for workplaces

The Commission heard that businesses want clarity about what to do to support the mental health and wellbeing of their workers.[222] Beyond Blue told the Commission that 'many employers report being confused about what to do and overwhelmed by the quantity of information provided by government agencies, NGOs [non-government organisations] and commercial offerings'.[223]

All participants at the Commission's roundtable, including several large, well-resourced organisations, agreed that more support and guidance were needed to help their organisations bolster mental health in the workplace, and to respond to employees' mental health and wellbeing needs. The Productivity Commission highlighted that some employers are drawing on strategies and programs they think will support their goals, but there is limited or poor-quality evidence of their effectiveness.[224] This means many are implementing initiatives that are not informed by evidence. A participant at the Mentally Healthy Workplaces Roundtable stated:

> right now there's a whole heap of interventions … available, but we don't actually know how effective they are. So that does need to be some sort of measurement or meta metrics to evaluate those things, as everyone said, but in terms of measuring, I think it's really important to be able to measure … what's the effectiveness at an individual level, as well as at an organisational level.[225]

There is currently no overarching framework for mentally healthy workplaces, although the Commission is aware that the Mentally Healthy Workplace Alliance is leading the development of a 'core framework' for mentally healthy workplaces through the National Workplace Initiative. Further, the Commission has heard of the need to ensure resources to support implementation of mentally healthy workplaces are not 'one size fits all', and instead are tailored to the workplace.[226] Mr David Morrison AO, Chair, Board of the Diversity Council Australia advised the Commission that '[w]e have to be very careful not to define responses to problems that are too holistic because that does not work in an area as complex as this'.[227]

The World Health Organization, in its 2010 framework for healthy workplaces, cautions that:

> There can be no template of healthy workplace practices that can be followed. While there are a few basic guidelines that every organization needs to follow, the concept of an ideal workplace will differ from industry to industry and company to company. A healthy workplace strategy must be designed to fit the unique history, culture, market conditions and employee characteristics of individual organizations.[228]

Participants at the Mentally Healthy Workplaces Roundtable agreed. One participant commented that 'our sectors face different challenges that impact people's mental health [a]nd we need to make sure that we're addressing those industry specifics as well as coming up with generic programs'. [229] They explained:

> one thing that we've tried to do … is recognise what is unique about the [redacted] sector and develop resources and interventions that address that uniqueness, whether it be … helping an individual who's going through a certain set of circumstances or trying to drive cultural change through organisations or through the whole sector.[230]

Participants at the roundtable told the Commission that small business, contractors, sole traders and start-ups often do not have the infrastructure and resources needed to design and deliver mentally healthy workplace programs and supports:

> these aren't organisations that need huge, great big [E]mployee [A]ssistance [P]rograms or HR programs, they just need to get their hands on things that are low cost and easy to implement for the non expert.[231]

The Arts Wellbeing Collective case study is an example of an industry approach to develop resources, tools and supports that are tailored to the specific needs of their industry. These resources are shared across members of the collective including small businesses and those who are self-employed.

In delivering the reforms outlined in this chapter, the Victorian Government should have an explicit focus on supporting small businesses, contractors, sole traders and start-ups, in addition to larger and more established businesses.[232]

Better pathways between workplaces and the mental health and wellbeing system

At the Mentally Healthy Workplaces Roundtable, business leaders described a need for stronger connections between workplaces and the mental health and wellbeing system to support people requiring mental health treatment, care and support. One participant asked:

> how do we bridge the gap between what we probably typically provide internally around [Employee Assistance Program] and a whole host of other support services[?] … I think a lot of us feel out of our depth when it gets to that point.[233]

Workplaces also recognised the critical role employees can play in encouraging peers to seek advice from a health professional for their mental health. Mr Chris Lockwood, National CEO of MATES in Construction Australia, Queensland, told the Commission:

> We want to apply that help-offering behaviour to mental health. We want to equip men with the skills to approach a colleague and say, '[m]ate, you're not looking too good. Can we have a chat about where you're at?' An offer like that can open up an honest conversation. Some people, and particularly men, may be a bit guarded, but you'd be surprised how people will open up when they're approached in a genuine way.[234]

Starting at the top to support mentally healthy workplaces

Stronger leadership and coordination is needed. Supporting mentally healthy workplaces is the responsibility of everybody in the workplace, but it must be led by the organisation's most senior leaders. In his statement to the Commission, Mr Radford stated that '[a] mentally healthy workplace requires leaders who demonstrate commitment to mental health in the workplace and manage workplace relationships respectfully.'[235]

The importance of leadership in changing workplace culture has been impressed on the Commission by several witnesses. Mr Morrison told the Commission '[t]he more we see people who have the courage to say "well, look I'm not travelling well" and actually make it clear to their workforce or colleagues, the more it will change culture.'[236]

Ms Annese described to the Commission how the behaviour of leaders sets the tone for the organisation and influences how others act. Ms Annese told the Commission:

> When deciding whether to disclose, individuals will take their cues from many things. They will look at what the leadership of the organisation says and what the infrastructure is like in the organisation. They will also look to the culture of the organisation. Culture is an invisible thing that happens based on the interactions that every individual has with everybody else every day, which can vary from team to team.[237]

Case study:

Arts Wellbeing Collective

The Arts Wellbeing Collective is an Arts Centre Melbourne initiative that brings together more than 400 arts and cultural organisations to promote positive mental health and wellbeing in the performing arts industry.

In 2016, research showed that symptoms of moderate to severe anxiety were 10 times more prevalent and suicide attempts were more than double for Australian entertainment industry workers compared to the general population. Risk factors specific to the industry, such as job security and concerns about stigma affecting future career opportunities, were identified as contributing to these statistics.

The following year, Arts Centre Melbourne launched the pilot of the Arts Wellbeing Collective. After a positive evaluation that found there was 'a desire for the program to continue and expand', the program was expanded through funding from WorkSafe Victoria's WorkWell Mental Health Improvement Fund.

The Collective works at three interconnected levels and aims to:

- build knowledge and skills in individuals through the delivery of workshops, toolkits, resources and support, including a 24/7 helpline staffed by psychologists with specific, dedicated training in performing arts challenges
- develop organisational capacity for improved wellbeing through consultancy and advice, how-to guides and organisational psychological safety assessments
- advocate for system-level changes by engaging with important sector stakeholders, to embed positive industry-wide change.

Arts Centre Melbourne wrote in its submission to the Commission:

> **The performing arts community needed little convincing of the importance of mental health, the need for early intervention and peer support, and the timeliness of addressing creative workplace practice. This is possibly due to the high prevalence of mental health problems … leading to a heightened understanding of the issue, and a drive to do something practical in this space.**

Arts Centre Melbourne noted that '[e]very resource, workshop and initiative is assessed by experts, from clinical to organisational psychologists, and dietitians to mindfulness instructors'. All elements of the Collective are codesigned with performing arts practitioners, ensuring it is relevant to the industry, and are accessed free of charge.

Source: Arts Centre Melbourne, *Submission to the RCVMHS*, 28 March 2019; Arts Wellbeing Collective <artswellbeingcollective.com.au> [accessed 9 November 2020]; WorkSafe, Mental Health Improvement Fund Round One Recipients <www.workwell.vic.gov.au/workwell-mental-health-improvement-fund-round-one-recipients> [accessed 18 November 2020].

Mr Morrison highlighted the importance of education and training to develop an inclusive culture that supports mental health and wellbeing:

> when people have a fear of disclosure, and concerns that stigma will be attached to them if they offer their true self at work, a lot of the pressure is actually at a peer level. That is why education and training is so vital, and needs to be cascaded throughout all organisations, because it is in a small team level that human interaction is at its most vital and where people's concerns are probably the deepest.[238]

The Commission considers there have been limited efforts within Victoria to foster leadership for mentally healthy workplaces at the organisational level, and that there is a gap in state-level leadership to bring industry and government together to steward change.

Measures to strengthen accountability and commitment

There is no agreed or measurable definition of what a mentally healthy workplace is,[239] which makes it inherently difficult for workplaces to measure or understand the extent to which they are reaching that objective.[240] This lack of definition and of progress indicators means workplaces are not able to monitor progress or determine the return on investment for mentally healthy workplace interventions.[241]

WorkSafe Victoria has advised the Commission that its measures for mental health in the workplace are limited and are collected mainly through its compliance and enforcement activity and workers' compensation claims.[242]

A participant at the Mentally Healthy Workplaces Roundtable told the Commission that public reporting on industry agreed measures for mental health and safety in the workplace would raise its profile from a human resources matter to a matter for senior leaders.[243]

Broader efforts

Mentally healthy workplaces are also a priority for the Commonwealth Government. The National Mental Health Commission convenes the Mentally Healthy Workplace Alliance, a national collaboration across government, industry and non-government members[244] to advocate for stronger action on mentally healthy workplaces.[245] The Mentally Healthy Workplace Alliance leads the National Workplace Initiative which 'will support employers, industries, small businesses and sole traders to create mentally healthy workplaces that enable workers to achieve their best possible mental wellbeing' and be employers of choice.[246] The initiative will establish a national approach to mental health in the workplace, providing business with 'assistance and guidance on how to build work environments that promote good mental health, reduce mental illness, and help people recover when they are unwell.'[247]

The National Mental Health Commission, together with the Mentally Healthy Workplace Alliance, recently released a series of guides 'to support the mental health and wellbeing of Australian workers and to encourage mentally healthy workplaces during COVID-19.'[248]

Further, on 27 August 2020, the Commonwealth Government announced that it had expanded mental health and wellbeing services for small business.[249] These services will be available through the Ahead for Business initiative hosted by Everymind.[250] Ahead for Business is a digital platform that includes articles, podcasts, videos and case studies designed to help small business owners and their staff support mental health and wellbeing in the workplace.

WorkSafe Victoria's role as regulator of occupational health and safety includes promoting education and training to eliminate risks.[251] WorkSafe has published guidance material regarding mental health issues and risk factors in the workplaces[252] such as bullying, sexual harassment and work-related stress.[253] It has also established a dedicated psychosocial inspectorate that monitors and enforces compliance with the *Occupational Health and Safety Act 2004* (Vic).[254] The psychosocial inspectorate focuses on ensuring that employers are providing a workplace 'that is free from risks to psychological health and safety'.[255]

WorkSafe Victoria also established the WorkWell program. Funded for five years, WorkWell is a collaboration between WorkSafe Victoria and the former Department of Health and Human Services to assist employers to create mentally healthy workplaces. WorkWell has a digital platform that provides information and resources to businesses on mentally healthy workplaces, learning networks that bring workplaces together to collaborate on practical ways to improve workplace cultures, and a Mental Health Improvement Fund to provide grants to workplaces to promote positive mental health and prevent mental injury.[256] WorkWell has been well received by stakeholders in the field. Ms Harman told the Commission:

> **The WorkWell program … is really starting to roll out some really interesting initiatives, giving grants to a range of workplace settings … to help them to design themselves the kind of workplace strategies that are to work for their employees and produce, not only great places where people look forward to going to and spending time … but also they're workplaces that are highly productive and show a really positive return on investment on very simple strategies that can be applied in a workplace.**[257]

Beyond government investment, many organisations have played a key role in supporting workplaces to make mental health and wellbeing a priority. Organisations such as Beyond Blue, SuperFriend, the Black Dog Institute, SANE Australia, Everymind and the Victorian Mental Wellbeing Collaboration have each supported business to develop workplace programs, train organisational leaders to lead cultural change, equip managers with the practical skills to support their staff and build an evidence base of what works.

Two examples led by the private sector include the Corporate Mental Health Alliance Australia and the Healthy Heads Organisation. The Corporate Mental Health Alliance launched its business-led alliance in October 2020 as a place to share insights and experiences about the creation of a mentally healthy workplace for their staff. The Healthy Heads in Trucks and Sheds charitable organisation is aiming to improve mental health and wellbeing in the logistics and warehousing industry (refer to case study).

11.3.3 Promoting mentally healthy workplaces

Mr Morrison told the Commission, 'you cannot just wish a better working place, you have to have plans for it.'[258] The Victorian Government has an opportunity to help business make these plans and lead the way in supporting workplaces across the state to promote and support mental health. Additionally, the government can use its regulatory responsibilities, through WorkSafe Victoria, to educate, monitor and enforce obligations for healthy and safe workplaces. It can also leverage its role as a large employer and procurer of goods and services and its capacity to influence and support employers across the state.

A new framework and resources for mentally healthy workplaces

The Commission considers there is a significant opportunity to build on the goodwill and ingenuity of workplaces to support the mental health and wellbeing of Victorians through the development of a new Victorian mentally healthy workplaces framework.

This framework will align with and build on the core framework being developed by the National Workplace Initiative by recognising and responding to Victoria's unique context, to support small, medium and large workplaces across Victoria to implement mentally healthy workplace strategies. It will describe the roles, responsibilities and practices of workplaces to:

- promote mental health
- reduce risk and minimise harm to prevent psychological injury at work
- create workplaces which are inclusive and free from stigma and discrimination
- support people experiencing mental illness.

In developing the Victorian mentally healthy workplaces framework, the Victorian Government should consider LaMontagne's integrated intervention approach for workplace mental health,[259] including its focus on promoting positive mental health in the workplace and supporting people experiencing mental illness, regardless of whether it is the result of a workplace mental injury.[260]

The promotion of positive mental health refers to the values and practices of an organisation that support people to feel valued, fulfilled and connected.[261] In practice, it includes focusing on strengths, modelling positive leadership behaviours, ensuring work is meaningful[262] and building social capital and a supportive workplace culture.[263]

Evidence presented to the Commission indicates that for workplaces to effectively protect and promote the mental health and wellbeing of their employees, they need to do more than the minimum legal requirement to prevent harm and minimise risk.[264] The Commission believes that approaching the Victorian mentally healthy workplaces framework in this way offers a comprehensive approach that will bring together employers' existing obligations to provide a safe and healthy workplace free from discrimination and harassment, and offer the opportunity to align policies and practices for inclusion with mental health and wellbeing approaches.

The framework will position mental health in the workplace as 'everyone's responsibility', considered in 'every way that the workplace does business'.[265] This way 'everyone contributes to a culture where people feel safe and supported to talk about mental health', support is tailored to different needs and everyone can see mental health and wellbeing is a priority.[266] The Victorian mentally healthy workplaces framework will create a common language that shapes the way mental health is spoken about in the workplace and will define expectations and responsibilities of workplaces and employees.

The Commission recommends that the Victorian Government develop a suite of evidence-informed information, resources and tools tailored to business type, size and geographic location that build on Workwell resources, to complement the Victorian mentally healthy workplaces framework.

At a minimum, the Victorian Government will develop a suite of tools by 2023 that includes:

- a digital mentally healthy workplace self-assessment tool tailored to business size, type and geographic location. This tool will help businesses identify what they are doing well, where more effort is needed and practical next steps, and to monitor the business's progress over time. It will be aligned with the business's size, resources and aspirations
- a recognition program for workplaces that implement the Victorian mentally healthy workplaces framework or equivalent. The recognition program should be graduated and recognise those that have started to make change and are meeting legal obligations, those that can demonstrate impact on risk factors, and those that can demonstrate excellence through a long-term commitment to a comprehensive approach
- tools and resources that are tailored to workplace type, size and geographic location
- provision of training on the importance of mentally healthy workplaces and the new framework targeted to board members and leaders of organisations, for example, as a short course offered by the Australian Institute of Company Directors or a program of Leadership Victoria.

The tailoring of tools to workplace type, size and geographic location will be phased over time. The Victorian Government should prioritise those industries, employer segments and employee groups that have higher workplace mental health injury claims identified in Figure 11.8, and those industries, employer segments and employee groups hardest hit by COVID-19 restrictions.

In developing the new framework, tools and resources, the Victorian Government should draw on the knowledge and expertise of large organisations and industries that have been active in their endeavours towards mentally healthy workplaces.

Box 11.1: Impact of COVID-19 restrictions on the arts and creative sector

In 2018 the arts and the creative sector contributed over $111 billion to Australia's economy[267] and 'employed over 600,000 people, more than mining and aviation combined'.[268] The creative and performing arts sector is an example of an industry that has been disproportionately impacted by COVID-19, given it is 'the first industry to shut down and likely the last to start again'.[269] Estimates indicate that up to 75 per cent of employees could lose their job as a result of COVID-19 restrictions and shutdowns.[270]

Live music has also been severely impacted, with estimates that at April 2020, some 12,600 people had lost income totalling $340 million.[271] Many artists are casual or contract employees who have more than one job, and with their fall-back job often being in the hospitality industry 'most of their work dried up immediately'. [272]

Healthy Heads in Trucks & Sheds case study is an example of an industry collaboration to improve the mental health and wellbeing of warehouse and logistics workers.[273] This is the first national industry-wide approach to improve mental health and wellbeing.[274] The initiative involves employers, employees, contractors and unions across the industry working together to identify the issues and develop solutions. It is an example of a integrated approach as proposed for the new Victorian mentally healthy workplaces framework.

Digital platform to assist businesses to access resources and build capability

The Victorian Government should build on WorkWell's digital platform as the mechanism through which to distribute and share the framework, tools and resources so that employers and employees have access to information through a central and trusted source for workplace health and safety information.

Given the importance of leadership in effecting genuine and appreciable cultural change, the Victorian Government should develop and fund the provision of free online training for small business owners. The training should focus on teaching managers how to recognise early signs of poor mental health and how to have a conversation with employees about mental health. This training should include simple strategies to provide reasonable adjustments to better support mental health and wellbeing. This training should include targeted information to support sole traders, farmers, contractors and start-ups to help them identify when they should seek help and how they might modify their own work-based mental health risk factors.

As a result of the new framework and associated tools and resources, more businesses will have active mentally healthy workplace strategies, and managers will be more confident to identify the warning signs, start a conversation about mental health and wellbeing, and to support their employees' needs. Good practice will be promoted and shared across industries, sectors and workplaces. In particular, employers will be supported to understand their obligations under the *Equal Opportunity Act 2010* (Vic). This includes understanding direct and indirect discrimination, how to comply with the Act (for example, through reasonable adjustments), and how to put in place measures to prevent discrimination (required under positive duties).

A Mentally Healthy Workplaces Consortium

The Commission recommends that, as part of the Mental Health and Wellbeing Cabinet Subcommittee, the Victorian Premier, together with the Victorian Chamber of Commerce, establish a Mentally Healthy Workplaces Consortium by the end of 2021. This will comprise employers, employees, unions, industry associations, the Mental Health and Wellbeing Promotion Office of the Department of Health, the Mental Health and Wellbeing Commission and key stakeholders in mentally healthy workplaces to steward change across Victorian workplaces. Figure 11.10 provides an overview of the Mentally Healthy Workplaces Consortium.

The Mentally Healthy Workplaces Consortium will:

- work collaboratively with the Victorian Government to inform the development of the Victorian mentally healthy workplaces framework and the suite of tools and resources to support business
- champion change, fostering commitment among businesses to establish mentally healthy workplaces
- build partnerships between workplaces, government and WorkSafe Victoria to try new approaches to tackle long-standing risk factors for poor mental health and build the evidence base of what works
- identify opportunities for greater transparency in public reporting on mentally healthy workplaces by business and government, including performance measures
- support partnerships between employers and the mental health and wellbeing system to support people experiencing psychological distress or mental illness
- advise on and oversee the mentally health workplaces industry-based trials described below.

The consortium should also provide advice on strategies to elevate mental health and wellbeing from a human resources matter to a senior leadership issue. The Productivity Commission noted it is 'difficult to regulate for, or impose the necessary leadership in an organisation to improve mental health in the workplace'.[275] This is why the Commission is encouraging the consortium to identify strategies to engage with senior leaders on this matter.

At its formation, the consortium should:

- establish a subcommittee of employee representatives to ensure that the employee perspective and voice informs the work of the consortium. Employee representatives should reflect a diverse range of occupations and community demographics and should include people with lived experience of mental illness or psychological distress. There should be a minimum of three employee representatives on the consortium
- include diverse representation of associations to represent those workplaces that have a high need for support but lack the structures and resources of large organisations
- draw on the expertise and lessons of large organisations that have taken steps to achieve mentally healthy workplaces.

The consortium and the delivery of its initiatives should be supported by the Department of Premier and Cabinet, which will act as secretariat of the consortium for the first three to five years. A core team within the Department of Premier and Cabinet, including executive leadership, will draw on expertise from WorkSafe Victoria, the Mental Health and Wellbeing Promotion Office of the Department of Health, the Department of Jobs, Precincts and Regions and the Mental Health and Wellbeing Commission. It should also engage with the Gender Equality Commissioner and the Department of Families, Fairness and Housing, to align and develop initiatives to reduce discrimination, including racism, and support workplace inclusion.

The secretariat will support the consortium and develop the new Victorian mentally healthy workplaces framework, tools and resources, and manage the mentally healthy workplace industry trials. After this initial three-to-five-year period, the Victorian Government should consider whether responsibility for the initiative is moved to the minister overseeing the jobs portfolio for ongoing management, together with the minister with the portfolio for WorkSafe Victoria.

Figure 11.10: Mentally Healthy Workplaces Consortium

Mentally Healthy Workplaces Consortium

The consortium will be a key initiative of the Mental Health and Wellbeing Cabinet Subcommittee.

The consortium will be co-chaired by the Premier and the Victorian Chamber of Commerce and Industry.

Membership will include employers, employees, unions, industry associations, the State Mental Health and Wellbeing Promotion Advisor, Mental Health and Wellbeing Commission and key stakeholders in mentally healthy workplaces.

The consortium will establish a subcommittee of employee representatives that reflect a diversity of occupations and community demographics and include people with lived experience of mental illness.

A minimum of three employees should be represented on the consortium.

Role:

- work collaboratively to steward change across Victorian workplaces
- foster commitment of the business sector and champion change
- focus on supports for small business, leveraging the expertise and lessons of large organisations
- advise government on the development of the Victorian mentally healthy workplaces framework and supporting tools and resources.
- advise on and oversee the implementation of industry trials

Secretariat

The secretariat for the consortium should sit within the Department of Premier and Cabinet. A core team supporting this initiative within the Department of Premier and Cabinet should include senior executive leadership and draw on expertise from WorkSafe Victoria, the Mental Health and Wellbeing Promotion Office of the Department of Health, the State Mental Health and Wellbeing Promotion Advisor and the Mental Health and Wellbeing Commission.

Victorian mentally healthy workplaces framework and supporting tools and resources

The Victorian mentally healthy workplaces framework will support small, medium and large workplaces across Victoria to implement mentally healthy workplace strategies. It will describe the roles, responsibilities and practices of workplaces to:

- promote mental health
- reduce risk and minimise harm to prevent psychological injury at work
- create workplaces that are inclusive and free from stigma and discrimination
- support people experiencing mental illness.

The framework will be supported by:

a) a suite of tools and resources including:

- a mentally healthy workplace self-assessment tool
- a recognition program for workplaces
- resources that are tailored to the specific needs of the industry

b) Capability and skills development programs including:

- free online mental health training for small business owners
- mentally healthy workplaces training for board members and leaders of organisations

c) Measures to strengthen accountability and transparency through public reporting

d) Stronger connections between workplaces and mental health supports.

Case study:

Healthy Heads in Trucks & Sheds

Healthy Heads in Trucks & Sheds is a not-for-profit charitable foundation that promotes the prevention and understanding of mental health issues for workers across the road transport, warehousing and logistics industry. Woolworths Group, Coles, Linfox, Toll, Qube, Ron Finemore Transport and Australia Post have all combined as corporate partners of the foundation with support from the National Heavy Vehicle Regulator and the Federal Government.

Healthy Heads in Trucks & Sheds launched in August 2020 as the first single national approach to tackle issues related to mental health and wellbeing in the industry as a whole. Mr Chris Wilks, Group Manager, Safety, Health & Wellbeing at Linfox said the strategy is informed by consultation and research identifying critical mental health issues affecting the industry.

> Linfox commissioned a study from Monash University in collaboration with the Transport Workers Union; it was a collaborative approach to understand the health concerns of our drivers in the transport industry. There is evidence that professional drivers face significant challenges, and we co-funded this study to help us address these challenges. We've been able to draw on deep insights from the research findings to build and strengthen a program for our business and industry to ensure that we're targeting the areas of concern, and supporting our drivers to be safer.

Mr Wilks explained Healthy Heads in Trucks & Sheds is built on three main areas: increasing the number of people trained in mental health at road transport facilities nationally; standardising policies and processes across transport and logistics industries to de-stress the environment for drivers; and focusing on individual mental health and improved wellness through education and resources around factors such as diet and exercise.

> Setting up a support network using trained mental health practitioners who have hands on experience in the industry is a really important step. We hope that building trust through a peer to peer approach will lead to drivers feeling more comfortable to talk openly about the real issues that they encounter every day.

Participation of smaller operators is funded by the larger founding industry members so everyone in the industry benefits.

Source: RCVMHS, *Interview with Chris Wilks and Marian Merrigan*, November 2020; Healthy Heads in Trucks & Sheds <www.healthyheads.org.au> [accessed 26 November 2020].

The Victorian Government may, in time, consider implementing legislative requirements to ensure large organisations develop and undertake comprehensive mentally healthy workplace approaches. The *Gender Equality Act 2020* (Vic) could be used as a model to inform this approach.[276] This legislation requires some organisations to complete a gender equity audit, implement an action plan and report on their progress. A similar approach could be applied to the establishment of mentally healthy workplaces, and the consortium should consider the risks and merits of this option as part of its work.

Building the evidence base for what works

The Commission recommends the Victorian Government implement a minimum of five mentally healthy workplace industry-based trials by 2024. These should each run for at least three years to test and develop guidance for applying the Victorian mentally healthy workplaces framework, and to build evidence for developing industry-specific tools and resources.

The trials will demonstrate best practice and test the effectiveness of an integrated mentally healthy workplace approach as will be described in the new Victorian mentally healthy workplaces framework.

The mentally healthy workplace industry trials will be designed to:

- test the efficacy, impact and potential of the framework
- determine how the framework can and should be adjusted to meet the needs of particular sectors or industries
- demonstrate a collaborative approach to research and evaluation, bringing together employees with lived experience of mental illness or psychological distress and employers to identify and deliver potential solutions
- determine how industries can best be supported to identify the broad range of mental health risk and protective factors, including discrimination and inequality, and take action to address them
- determine the impact and benefits of sector- or industry-wide approaches to build business engagement on mental health and wellbeing, and develop a common language and shared objectives between employers and employees
- test the utility of industry-specific approaches and tailored resources to address mental health and wellbeing risk and protective factors.

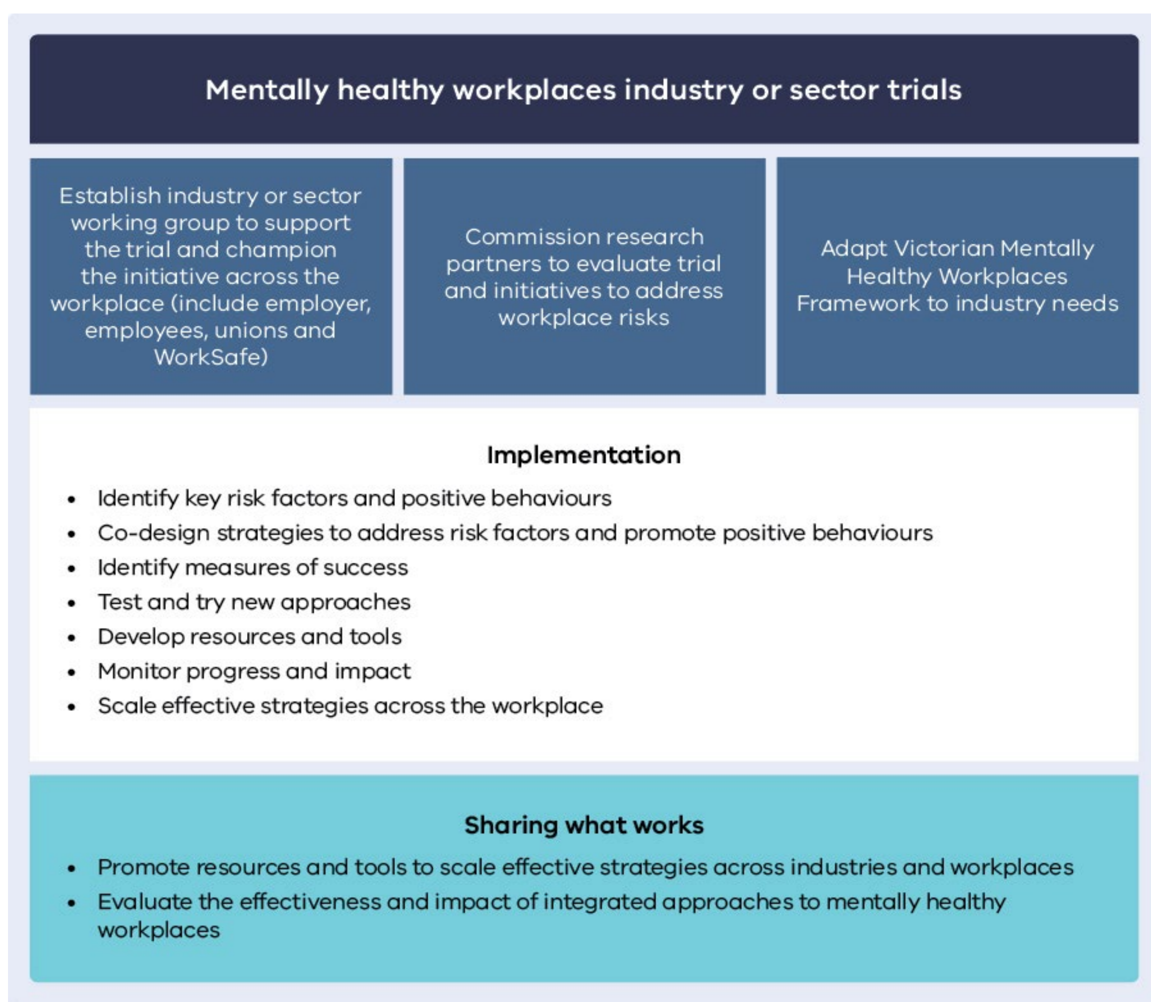
They will also be designed and implemented with the intention of contributing to the evidence base by:

- testing and trialling new approaches to address workplace risks and promote positive behaviours
- testing and trialling new approaches to support inclusion and reduce stigma and discrimination in the workplace
- establishing data collection and monitoring approaches to monitor and report progress over time
- informing industry or sector-specific guidance that would support scaling the approach across other workplaces.

These trials will occur in priority industries and sectors described in Figure 11.8, where there is a high proportion of mental health injury claims and/or where a sector or industry has been disproportionately impacted by the COVID-19 restrictions. The trials should be of sufficient scale and breadth to deliver on the objectives described, engage broadly across the workforce, identify risks across the industry, and test and trial approaches to improve the mental health and wellbeing of workers.

Figure 11.11 describes the key features and functions that would be included within each industry or sector-based trial.

Figure 11.11: Industry-based trials to create mentally healthy workplaces



These trials should build on the lessons from the WorkWell Mental Health Improvement Fund, described in Box 11.2. A key difference in the Commission's recommended approach is its focus on testing industry-wide approaches to application of a tailored, integrated, mentally healthy workplaces framework.

Box 11.2: WorkWell Mental Health Improvement Fund

The WorkWell Mental Health Improvement Fund is a grants program that provides large-scale investment to support businesses promote mental health and wellbeing and prevent mental injury and illness in the workplace.[277] The initiative has funded 25 projects at a value of $25 million.[278]

The fund targets those workers at greatest risk of mental injury, such as frontline workers, young workers, ageing workers and workers in industries of transition.[279]

Recipients of grants include industry associations, unions, businesses and not-for-profit organisations to develop and test new approaches to address risks and needs of people vulnerable to workplace mental injury.[280]

The Victorian Government should also continue to resource WorkSafe Victoria's WorkWell initiative after the current funding lapses. WorkSafe should focus its efforts on:

- building the evidence base to inform what works to reduce the risk of poor mental health at work and to promote mental health and wellbeing
- supporting implementation of the Victorian mentally healthy workplaces framework
- measuring the impact and benefits of the Victorian mentally healthy workplaces framework
- sharing knowledge and expertise across workplaces.

11.4 Supporting mental health in the places where we learn

The Commission envisages a future in which all Victorian education settings are supported to play a positive role in promoting mental health and wellbeing for all members of their community. As part of this vision, schools will play a stronger role in promoting good mental health and wellbeing. School leaders and staff will have a clear understanding of how their role complements those of many other settings and services which support mental health and wellbeing, and they will have the resources to fulfil that role in a way that is meaningful and tailored to the needs and priorities of school communities. The recommendations outlined in this chapter will provide teachers and school communities with the knowledge and capability to identify early signs, access programs and resources to better support the mental health and wellbeing of their students, and provide clear pathways for referral to services when needed.

The Commission recognises that the education sector is constantly adapting in order to better meet the needs of children and young people. The reforms outlined in this section have been designed to support school leaders and staff to integrate the promotion of mental health and wellbeing into their planning and delivery across teaching and learning, school culture and environment, and make referrals to treatment, care and support services where required.

11.4.1 Education as a priority setting

Education settings—that is, the places where children, young people and others go to learn and be educated—are a key place where mental health and wellbeing can be supported and promoted.[281] Education settings include early learning, pre-primary, primary and secondary schools, and tertiary institutions including universities and vocational learning centres.

Professor Sir Michael Marmot, Director, Institute of Health Equity at University College London, gave evidence to the Commission in a personal capacity and recommended that governments prioritise mental health in early childhood:

> Governments seeking to support good outcomes among people living with mental illness should focus their policies and actions on early childhood. The research on mental health of children and young people indicates that acting in early childhood will have a substantial impact on future mental illness in adulthood.[282]

Similarly, Ms Harman said:

> Early childhood education and schools offer ideal settings for promoting healthy behaviours early in life. The benefits of this extend beyond educators and students, to parents, families and the broader school community.[283]

In its submission, the Local Learning and Employment Networks (LLENs) highlighted the link between mental health and young people's entry into the tertiary sector and beyond. It said:

> Of particular interest to LLENs is the impact of mental illness on young peoples' ability to cope with transitioning from primary to secondary school, their ability to attend education regularly, and the capacity of young people to make informed decisions about further education and work.[284]

Young people who spoke directly to the Commission highlighted the role of education settings in supporting their mental health. In the human-centred design sessions the Commission conducted with young people with lived experience, participants identified the need for mental health and wellbeing education for school-aged children and consistent 'check-ins' to support early intervention.[285] One participant proposed that more needs to be done to 'teach young people how to understand their emotions so that they may avoid alcohol and drug use'.[286]

Evidence indicates that early intervention in emerging mental health issues during childhood can help prevent or reduce the severity of mental health issues through to adolescence and adulthood, and their associated impacts on physical health, life expectancy and social and economic participation.[287] The Commission has taken these variations into consideration in shaping the priorities and focus of its recommended reforms. In particular, the Commission recognises that there are specific opportunities to influence mental health and wellbeing activity within primary and secondary schools.

11.4.2 The influence of education settings on mental health

There are many ways that education settings can influence mental health and wellbeing. Almost all children and young people engage with these settings, and so the opportunity for mental health promotion and prevention efforts is significant. Education settings are also important settings where support can be provided for children and young people who are experiencing mental illness or psychological distress.[288] In the latter, education settings may have a more critical role in areas where treatment, care and support options may be limited, such as in rural and regional areas.

Universal participation

In Australia, most children and young people spend a high proportion of their lives in education settings, beginning with early childhood services and kindergarten, through to schools and then in vocational education and universities. In fact, most Australian children and adolescents spend around one third of their time at school, more time than in any other formal institution.[289]

In its submission to the Commission, the Victorian Government recognised the critical link between education and mental health and wellbeing. It described how 'universal' service settings in Victoria, including early childhood settings and schools, can provide treatment, care and support 'without excessive disruption to a person's daily life'.[290] It also recognised the critical role TAFEs and universities play in this regard.[291]

The Australian Education Union echoed this sentiment:

> The mental health of students in schools, preschools and TAFE institutions is as important as their physical health and … there is a clear connection between student wellbeing and learning progress. This means that public education institutions should be safe, supportive and inclusive learning communities with the necessary resources to effectively carry out this role. And because of the crucial part they play in the lives of children and young people, these institutions should continue to implement positive strategies to nurture mental health and to identify and support those students who are experiencing mental health issues.[292]

Providing a foundation for mental health throughout life

Evidence before the Commission indicates that as it relates to mental health, 'the earliest possible intervention will be the most successful'.[293]

The Productivity Commission's *Mental Health Inquiry Report* suggested that a suite of education-focused reforms warranted 'priority' government attention because of the 'estimated improvement likely in the quality of life for people.'[294] This included reforms to 'help schools support the social and emotional wellbeing and mental health of their students',[295] which the Productivity Commission asserted 'should be a priority … [s]chools should have a clearly defined role in supporting the social and emotional wellbeing of students, with effective pathways to care.'[296] The Productivity Commission also stated that 'prevention and early intervention [efforts] should continue through tertiary education and employment'.[297]

The early years of life are a particularly formative time as children and young people navigate peer relationships and social interactions, and undergo significant behavioural, physical and emotional development.[298]

As described in detail in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, the Commission puts forward recommendations to support infant, child and family mental health and wellbeing within the mental health and wellbeing system. In particular, the Commission recommends the establishment of a responsive and integrated service stream to provide developmentally appropriate mental health and wellbeing treatment, care and support for newborns to 11-year-olds and their families. These reforms complement this chapter, which focuses on schools as a setting to deliver mental health and wellbeing programs.

Addressing poor mental health at the earliest stage

Evidence before the Commission indicates that mental illness often emerges early in life, with some estimates suggesting that half of all mental illness develops before the age of 14 years, and that 75 per cent of mental health conditions emerge by 24 years of age.[299] Mission Australia and the Black Dog Institute reported that for young people with psychological distress, the top three issues of concern were 'coping with stress, mental health and school or study problems'. [300]

The Australian Education Union mental health survey, carried out in June 2019, indicated that across Australia, 72 per cent of secondary teachers reported that self-harm had occurred in their schools in the past year.[301] In its submission to the Commission, the Victorian Government indicated that 40 per cent of all presentations to the Doctors in Secondary Schools program were related to mental health issues.[302]

These findings align with the fourth *Youth Mental Health Report* (2019), which indicated that the number of young people reporting they had experienced psychological distress had risen from 18.7 per cent in 2012 to 24.2 per cent in 2018.[303] The experiences of Aboriginal and Torres Strait Islander people were worse than their non-Aboriginal peers, with 31.9 per cent reporting that they had experienced psychological distress, and were almost three times as likely as non-Aboriginal peers to 'report feeling as though they had no control over their life'.[304] These figures pre-date the COVID-19 pandemic; the impact of COVID-19 on the mental health and wellbeing of Australian young people is not yet known.

Building supportive communities for student and family mental health and wellbeing

Mr Gregory McMahon, Executive Principal of Hallam Senior College and Strategic Director at Doveton College, described to the Commission the approach Doveton College has taken to build a strong and supportive school community:

> Doveton College seeks to support, foster and develop opportunities for all members of the Doveton community including children, young people, and adults. The focus is on providing high quality teaching and learning programs for young people aged 0–15 with additional learning opportunities for parents and members of the wider community.[305]

Mr McMahon explained that Doveton College has a diverse student population, with over 50 languages spoken by students and their families. Many students who attend Doveton College have experienced trauma or disadvantage.[306] Over a six-year period, the College identified 238 students as requiring mental health supports, with 230 students accessing free psychological services via the school.[307]

Doveton College has introduced the Our Place model, an initiative of the Colman Foundation, working in partnership with Department of Education and Training and ten schools across Victoria.[308] Our Place leverages the potential of schools to act as community 'hubs', and brings together the resources of government, non-government organisations, philanthropic and community resources to address structural causes of disadvantage.[309] Our Place supports Doveton College to provide early years' services, effective schooling, health and community services, adult education and employment support, and community engagement activities for children and families.[310] Through the provision of these services, Mr McMahon explained that Our Place provides a whole-of-family learning focus.[311]

At Doveton College, Our Place has achieved positive outcomes for students, families and the school community.[312] Mr McMahon explained that as a result of an 'extended day' initiative, which involves an early morning basketball program established in collaboration with the Doveton Gathering Place, attendance of Aboriginal young people at school has significantly increased.[313] Through Doveton College programs and initiatives, student outcomes across 'learning confidence, engagement and relationships', have risen from the bottom quartile in 2013-14, to the top quartile in 2017.

Mr McMahon said:

> They're just fantastic outcomes. You can't have young people developing if they're not at school, so in that sense school becomes the consistent, and then what we're doing in the school becomes the icing on the cake, it really does.[314]

Influencing the determinants of mental health and wellbeing

Mental health initiatives in education settings have strong potential to influence the risk and protective factors for mental health and wellbeing.[315] Key protective factors for children and young people include having strong social supports and positive social relationships, with education settings playing an important role in fostering these.[316] The Department of Education and Training identified that:

> a sense of connectedness or belonging to school and to family is the single most important protective factor for young people. It is associated with positive health and academic outcomes.[317]

Professor McGorry told the Commission that 'effectively intervening with key risk factors such as childhood trauma, bullying and other social factors' could reduce the prevalence of mental illness.[318] Some of these factors occur within the education setting, such as bullying and exclusion, and the setting itself can seek to prevent or reduce them. Others, such as family violence or childhood neglect, are likely to occur outside of the education setting. However, as their impacts and repercussions are experienced within it, there is an opportunity to address risk factors.

The Commission understands that trauma and adversity in childhood has been closely linked with negative physical, social and mental health outcomes and is a risk factor for poor school engagement.[319] Adverse childhood experiences include abuse and neglect, exposure to family violence and having a parent with a severe mental illness, alcohol/substance use disorder or history of incarceration.[320]

'Bullying' refers to any intentional and repeated behaviour which causes physical, emotional or social harm to a person who has, or is perceived to have, less power than the person who bullies.[321] There is no single comprehensive national data source on bullying.[322] However, data from the Longitudinal Study of Australian Children in 2016 indicated that seven in 10 children aged 12–13 had experienced at least one bullying-like behaviour within the year.[323]

Bullying and exclusion are linked to a range of physical, psychological, social and academic consequences for children.[324] Children who are victims of bullying are also at a higher risk of suicide.[325] Persistent bullying is also recognised as a source of trauma and has been linked to a range of post-traumatic mental health outcomes, including a diagnosis of post-traumatic stress disorder.[326] Whitelion, a charity that supports young people at risk in the Australian community, informed the Commission that young people said addressing issues such as bullying and cyber-bullying would help prevent poor mental health.[327]

In its submission, the Commission for Children and Young people presented a personal story of a young person who spoke of the damaging impact of bullying and exclusion:

> Some of the biggest issues around mental health for me are like bullying and that especially for kids. If people realise that this isn't ok and having some common sense it would have made a huge difference. For me when I was getting bullied it affected me quite a lot, actually it affected me heaps.

The young person described the impact on their sense of belonging and social connection:

> You just want to feel like you fit in and are part of the community, but instead people block you because of whatever issues and then you feel isolated, it's not nice being left out.[328]

Young people of diverse gender identities or sexual orientation are particularly vulnerable to harassment, with school being the most common location where this occurs.[329] Trans and gender-diverse young people are also more likely to experience harassment and discrimination, from both teachers and their peers.[330] Trans and gender-diverse young people who did not feel supported by their teachers were more than four times more likely to leave school if they experienced discrimination than those who had teacher support.[331] Such experiences can lead to higher rates of depression and suicide among these groups.[332]

Some evidence presented to the Commission identified that the negative use of social media is compounding the effects of bullying and exclusion and contributing to poor mental health. Dr Richard Haslam, Director of Mental Health at The Royal Children's Hospital, Melbourne, informed the Commission that emergency department presentations of depression and anxiety are rising for adolescents, which is associated with increasing rates of self-harm and suicide. He also observed:

> The increase in depression and anxiety, and related presentations to [emergency departments] is contemporaneous with the arrival of the smartphone, which causes one to wonder about the impact of social media on mental health.[333]

Professor Moodie argued that social media has a negative impact on the mental health of young people, particularly young women:

> Social media has a particular (negative) impact on young women and their body image, and … is also a platform for cyberbullying. These sorts of issues are probably much more impactful on someone aged 14 than they are on someone aged 34 or 54 or 74.[334]

A systematic review of online communication, social media and adolescent wellbeing revealed contradictory evidence on the impact of social media on the mental health and wellbeing of young people.[335] The review suggested some evidence of an increase in protective factors such as increased self-esteem and social support.[336] However, it also reflected increased exposure to harm, social isolation, depression and cyber-bullying. [337]

Current initiatives in education settings to reduce the impact of bullying, exclusion and cyber-bullying are discussed later in this chapter, as well as initiatives that recognise and respond to children and young people who are affected by trauma and adverse childhood experiences.

Supporting children and young people in rural and regional areas

Young people who live in rural and regional Australia have a higher reported incidence of mental illness and higher rates of suicide and addiction than their urban counterparts, though the empirical data is limited.[338] Evidence suggests that the social stigma towards mental illness and attitudes of stoicism and self-reliance are significant barriers to rural youth seeking and receiving effective help.[339] As detailed in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*, children and young people also face geographical and access barriers to receiving mental health and wellbeing treatment, care and support.[340]

In its submission, Goulburn Valley Health outlined some particular challenges experienced by secondary school-aged children and young people from the region. In four local government areas in the region, school children aged between seven and nine report bullying at significantly higher rates than the Victorian average. In secondary school-aged children and youth, hospital presentations in Greater Shepparton resulting from illicit substance use are among the highest in the state.[341]

Schools are an important setting to support children and young people living with psychological distress or mental illness in rural and regional areas.[342] Rural and regional schools can provide supports that are tailored to local need, and which address barriers to seeking and receiving effective support for poor mental health. In an Australian survey of 201 secondary students regarding their preferences in where they seek help for mental health, a preference for school-based help over clinic-based medical help was expressed.[343]

Kelly Duncan's story describes the lack of mental health supports in rural and regional areas, particularly for primary schools (refer to case study).

The role of educators in supporting mental health and wellbeing

Evidence indicates that developing trusted relationships with an adult who is supportive and encouraging is an important protective factor for mental health in children and young people.[344] On the other hand, low confidence and skills among professionals in regards to mental health can be one of the reasons young people are reluctant to seek help, among many other reasons.[345] The Australian Education Union highlighted that:

> Classroom teachers play a crucial role in the lives of the children and young people they work with on a day-to-day basis. They become a source of support for their students through relationship development and the building of trust and, particularly at the primary level, have a knowledge of and links to their families.[346]

Teachers and early childhood educators are in a good position to identify early warning signs and support families and young people to seek help. As Ms Harman explained:

> we need schools and early learning services to be literate in the signs and emerging symptoms of mental distress and psychological and behavioural issues, and we need the professionals working in those environments to have, not only the knowledge, but the confidence to be able to know what to do, what to say, how to work with families, when to work with families, but also to have the pathways very clear to them about how to support those young people, children and families towards more specialist support when they need it.[347]

In its Consensus Statement, the Prevention Coalition highlighted that educators in schools can play a key role in delivering skill-building programs and learning experiences that help to prevent mental health and substance abuse conditions.[348]

Supporting young people with lived experience

Evidence indicates that children and young people experiencing poor mental health are more likely to have lower academic achievement than their peers, miss more days of school,[349] and leave school early, which may result in social and economic exclusion[350] and limited employment opportunities.[351]

Research suggests that students with lived experience of mental illness:

- are behind their peers in Year 3 and fall further behind as they progress through school.[352] By Year 9, students experiencing poor mental health were '1.5 to 2.8 years behind' their peers who did not experience mental illness[353]
- missed an average of 23.8 days in secondary school compared with 11 days for their peers[354]
- achieved poorer educational outcomes if the student's family experienced socioeconomic disadvantage[355]
- had lower levels of connectedness to school and engagement with schoolwork.[356]

Tandem noted in its submission that 'children who become carers face particular difficulties in being recognised and having their needs met'.[357] According to the Department of Education and Training, young carers may be hard to identify by schools because of barriers to disclosure, as many young people with significant caring responsibilities do not see themselves as 'young carers'.[358] The department recognises that, 'schools can play a critical role in supporting young carers to engage and remain engaged in education through early identification and early intervention'.[359] The department provides guidance on how to identify young carers, and also a number of supports that can assist young carers to engage in and remain engaged in education, as well as to support their social and emotional wellbeing.[360]

Personal story:

Kelly Duncan

Kelly has been working in East Gippsland since early 2019, most recently as a Bushfire Recovery Practitioner and prior to that with Student Support Services with the Department of Education and Training.

Kelly works directly with a number of local schools and has seen firsthand the major impacts the recent summer bushfires have had on children and families, with an increase in trauma and other mental health challenges and a surge in complex mental health presentations in schools.

While there has been an increase in mental health support and funding for schools following the bushfires, Kelly said there hasn't been an increase in services for children under the age of 12.

> Counselling services for that age group (under-12) have been really hard to access in different areas, and that's been really difficult for schools to manage.

Kelly said that the challenges with access to services in East Gippsland have always been noticeable, but they have been made worse by the impacts of bushfires.

> Our area has always struggled with access to the private sector, with being able to get in to see psychologists, and especially people that are experienced in dealing with children.

Kelly explained that schools have led the way in recognising and responding to families and children with mental health challenges, particularly following the summer bushfires. Through existing mental health programs, teachers and staff at schools are being trained in how to approach social and emotional wellbeing for the whole school as well as targeted classroom strategies. Kelly noted this has not been easy.

> I also notice that school staff are often required to notice, enquire, respond and case manage the complex cases, often without external support.
>
> I guess the thing that I work on and that I've noticed especially is that in this period we're now also dealing with staff who are traumatised by their own bushfire experiences, which sometimes has impacts across whole school systems.

Kelly explained that there has been an increase in the number of complex cases being presented and that schools need more support to deal with them. She spoke about the benefits of schools and child and youth mental health services working together.

> The type of support that was really useful in the past is that schools and mental health services would work together to provide that complex case management of services to families and students.

Kelly said that from her perspective, East Gippsland schools need more support with these complex cases, child and youth mental health services need more staff and the community needs better access to psychologists and counselling services.

Source: RCVMHS, *East Gippsland Regional Roundtable: Record of Proceedings*, 15 September 2020.

Commission witness Miss Denna Healy spoke of her experience as a young carer. She explained that after her father was taken to hospital following a suicide attempt, she went to school the next day:

> Looking back now, I can't remember how I did that, but 16 year old me just felt like it was the only way I could cope. School was some sense of normality in a week where my life had been turned on top of its head.[361]

For Miss Healy, school provided important support.[362] Miss Healy outlined that central to the support of the school was access to ongoing counselling sessions, which she continued for three years until she finished school.[363]

Supporting children and young people to access help and providing an inclusive environment where all students are valued and encouraged to participate is critical to supporting better outcomes in the longer term.

Help-seeking behaviours and mental illness stigma

Many young people living with mental illness or experiencing psychological distress are reluctant to seek help, which can have a negative impact on their mental health and wellbeing.[364] The perceived stigma of mental illness is one reason that young people do not seek help. Other reasons include feeling embarrassed, not understanding the symptoms they are experiencing or preferring to 'figure it out' by themselves.[365] The Department of Education and Training acknowledged that 'students who experience discrimination or stigma are more likely to also experience reduced connectedness to school'.[366]

According to batyr, a charity that delivers a program to address stigma in schools, 'efforts to reduce stigma and discrimination through preventative education are important for creating supportive environments where those who are at risk of suicide feel comfortable reaching out'.[367] Programs that increase mental health literacy in teachers and young people can improve understanding of the early signs of poor mental health, address stigma, and help people understand when to seek help.[368]

As detailed in Chapter 25: *Addressing stigma and discrimination*, the Commission recommends the design and delivery of long-term anti-stigma programs to reduce the impact of stigma in a range of key settings, including schools.

11.4.3 Supporting action across various education settings

Early childhood and early learning settings

Early childhood education services offer an important setting to support the development of good mental health and wellbeing. Tim Moore, Senior Research Fellow of the Centre for Community Child Health at the Murdoch Children's Research Institute, giving evidence in a personal capacity, told the Commission, '[t]he foundations of resilience are best laid through the provision of universal services and supports in the early years that focus on the building blocks of mental health'.[369] Both the Victorian Government and the Commonwealth Government contribute funding to the early education sector.[370]

The Victorian Government funds a kindergarten program to a subset of early childhood services and the Commonwealth Government 'funds other early childhood education services, including long day care and family day care.'[371]

The Commission supports the Victorian Government's recent initiatives to improve children's school readiness by providing universal access to funded three-year-old kindergarten and the School Readiness Funding initiative.[372] The extension of three-year-old kindergarten to all children offers a chance to 'reach all developmentally vulnerable children' earlier[373] and identify children who may be developing poor mental health.[374] School Readiness Funding provides dedicated funding to build the capacity of kindergarten services, educators and families to support children's learning and developmental outcomes.[375] Consequently, the Commission has focused its reforms on supporting children and young people in primary and secondary schools.

Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* details the Commission's recommendation for dedicated funding to each of the 13 Infant, Child and Family Area Mental Health and Wellbeing Services, enabling them to provide secondary consultation to universal, primary and secondary tier services. As a priority, this will be provided to primary schools—in particular, wellbeing and support staff and staff from Student Support Services teams.

Tertiary education settings

The Commission recognises that tertiary education settings, including universities, TAFEs and other vocational education and training settings, can have a significant influence on the mental health and wellbeing of young people and young adults.

Universities

Orygen's report, *Under the Radar: The Mental Health of Australian University Students,* estimated that over 210,000 Australian university students aged 18–25 would experience mental ill-health in a given year, based on other prevalence data.[376] The Productivity Commission's *Mental Health Inquiry Report* found that tertiary students are more likely to experience poor mental than the general population.[377] The level and types of mental health-related support provided by tertiary institutions to students varies between education providers.[378] Further, demand for services, such as counselling, exceeds supply at many institutions.[379] Poor mental health in tertiary students is linked to poorer engagement in education, lower average grades and higher dropout rates.[380]

International students make up a significant proportion of the university student population in Australia. In 2018, there were more than 1.5 million university students,[381] 26.9 per cent of whom were international students.[382] Studies indicate that international students are at increased risk of experiencing poor mental health, with isolation from families and culture, language barriers, financial stress and academic pressures among the key drivers.[383] Further, international students have been found to be less likely to seek help for poor mental health than domestic students.[384]

The Productivity Commission's *Mental Health Inquiry Report* recommended that 'the accountability of tertiary education providers should be strengthened with expanded mental health support to their students, including international students'.[385]

It is the Commission's view that universities should work closely with multicultural and ethnospecific, community-led organisations across the state to support inreach into universities to engage with international students. Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* includes a recommendation to provide ongoing flexible funding to Victoria's diverse communities and community-led organisations to deliver mental health information, literacy and navigation into the mental health system. This will include funding to support ethnospecific or multicultural-focused organisations to partner with universities to help international students connect with others, to improve their understanding of the early signs of poor mental health, address stigma and help international university students to navigate access to services, and encourage early help-seeking behaviour.

In 2020 Orygen, funded by the Commonwealth Government, developed the *Australian University Mental Health Framework*.[386] The framework seeks to provide guidance for universities to develop mentally healthy settings which support the mental health and wellbeing of students.[387] It suggests a whole of university approach to build the capability of university staff to create environments that are inclusive,[388] and promotes universities partnering with the mental health and wellbeing system to provide joined-up and coordinated support to students.[389] The Commission supports the application of this framework in tertiary settings.

TAFE

The vocational education sector offers training programs to young people from 15 years of age and vocational education and training within schools, which can contribute to the completion of the Victorian Certificate of Education or the Victorian Certificate of Applied Learning. TAFE also offers pre-apprenticeships and apprenticeships. TAFE typically offers courses from Certificate 1 to Graduate Diploma. While the current funding system for TAFE includes loadings for young people, people from regional areas and Aboriginal people, there is no loading to support people living with mental illness.

A 2008 national survey of TAFE staff indicated that workers were concerned students were not disclosing that they were experiencing mental illness, which impacts their access to disability support services.[390] Staff reported that '[t]hese students are often not yet connected to community mental health services which may impact their wellbeing'.[391] Staff wanted protocols to provide clarity of their role,[392] and professional development to help them better support students to access help.[393] An Australian Education Union June 2020 survey of 263 TAFE teachers across 17 TAFEs found that little had changed:

> Very few respondents felt that their educational qualifications adequately prepared them to identify and support students with mental health or well-being issues (13.8 per cent) although around half agreed that their TAFE supported participation in professional development to identify and support these students (48.6 per cent).[394]

Mental health promotion, which could promote help seeking,[395] was identified as underdeveloped in TAFE settings, and staff could point to few examples of positive mental health promotion.[396] The Commission supports the suggestion in the *Australian University Mental Health Framework* that implementing the framework could act as a starting point for other higher educational settings, such as TAFE.[397] The Commission suggests that the Victorian Department of Education and Training work with the TAFE sector to progress mental health promotion in TAFE settings. The Department of Education and Training should also identify evidence-informed approaches to build the capability of TAFE staff to identify early signs of poor mental health and support students to get help from mental health and wellbeing services.

All TAFEs offer disability support services, but the way these services are structured varies significantly and they may be spread across campuses, affecting access.[398] Since 2014, the Victorian Government has provided TAFEs with community services funding to provide a range of services that complement and support mental health and wellbeing.[399] These include community engagement, outreach, literacy and numeracy and careers counselling. This funding is flexible, giving TAFEs the opportunity to choose what will best support their student community.[400] The Commission suggests that the Victorian Government identify the minimum level of service that each TAFE should provide to inform future allocation of community services funding.

11.4.4 Primary and secondary school settings—the Commission's focus

The Commission's recommendations for education settings focus on Victorian primary and secondary schools. As discussed earlier, there is strong potential for other education settings, such as early childhood and university settings, to support mental health and wellbeing. Based on evidence before it, however, the Commission has concluded that the highest unmet need is in primary and secondary schools.

The Commission also notes that there are significant reforms in progress at both the national and Victorian levels regarding mental health and wellbeing in education settings. The Commission's reforms aim to complement these initiatives.

The World Health Organization has long recognised the relationship between schools and health. Following the release of the *Ottawa Charter for Health Promotion* in 1986,[401] the concept of a 'health promoting school' gained traction. The *Health Promoting Schools Framework* articulated the critical role that education settings play, not only in educating students about health, but also in engaging educators, students, parents, health providers and the whole school community to understand the broad range of factors that can influence health, and to make the school setting one that promotes and supports health.[402] In this light, education settings have been described as an 'extended arm' of primary health care, with health efforts that are delivered in education settings benefiting not only children and young people, but also their families and the wider community.[403]

Evidence before the Commission makes a strong case for schools to continue playing this key role in promoting mental health, preventing mental illness, and supporting people with lived experience, as well as their families and carers. Schools provide 'strategic platforms' for delivering health promotion and prevention initiatives and are an efficient and effective way to reach large numbers of people.[404]

Personal story:

Jade

At only 15, Jade* has spent much of her life caring for family members who live with mental illness, and other health and neurodevelopmental issues. Jade's twin brother, older brother and father all experience anxiety and depression, as well as being diagnosed with autism spectrum disorder. This has had a significant impact on Jade's own mental health.

> It's tough being the child of a parent with a mental illness, as well as having siblings with mental health issues and disabilities. People need to understand that it can, and does, affect everyone in the family.

Jade reflected that as a twin, teachers often depended on her to help support her brother at school.

> When we were at the same school, my brother's teachers relied on me to be his main support. Even in kinder, I was always the one who had to help him ... Whenever he got angry, they pulled me out of class to calm him down because the teachers said they didn't know what to do ... A lot of time the adults used me as the de-escalation tactic, rather than learning how to do it themselves.

Jade has experienced challenges with her education as a result of her caring responsibilities and her mental health. Jade felt that at her previous school, the support that was put in place for her 'petered out' and the staff did not fully appreciate the effect of her mental health on her education. When Jade's mental health forced her to miss a term of school, she was disappointed none of the teachers or wellbeing staff reached out to her.

> I'm really committed to my studies and like to be involved in all the clubs, so for me to suddenly stop coming to school was really unusual. I feel like I could have been dead, and my school wouldn't have even noticed, because they completely ignored all the warning signs.

Jade has recently moved schools and now feels much better supported. However, there are still some challenges.

> Some teachers have started to do the 'but you got an extension on the last test' thing, as though they think I'm making an excuse. As a carer, it's not a once-off thing like someone being sick and getting better. It's as though some teachers think this can't just keep happening, but being a young carer does just keep happening.

> Although my teachers don't really understand the extent of my caring life, my school counsellor has a good understanding because [my mental health service] did a proper handover.

Jade speaks about the importance of handovers being comprehensive, and the effects of repeatedly telling her story when they are not done well.

> The hardest thing is having to tell your story all over again, especially for me, because my story is my whole life ... It's very draining and also I feel every time I have to tell my life story again, it gets a little less important. It's as though I get so used to it, it loses value.

Jade would like to see better recognition of her role as a carer, as her mother is often seen as the only carer. Jade strongly believes that young carers have valuable perspectives and notes their opinions are often overlooked.

> It is really important to listen and respect the opinions of young people. I think people may assume I am an over-dramatic teenager, but I have had significant life experience ... [O]ur age doesn't necessarily define what we know. Our lived experiences are resources that should be utilised.

Source: *Personal Story of 'Jade' (pseudonym), Collected by Tandem.*

Note: * Names have been changed to protect privacy.

As one young person explained to the Commission:

> School can be used as essentially a preventative measure. [Schools] can also increase mental health literacy, increase coping strategies, and … can also branch out within the wider community in breaking down stigma associated with mental ill health and even the cultural barriers that may be presented to the school or within the school.[405]

The Productivity Commission's *Mental Health Inquiry Report* recognised that the benefits of helping schools support the social and emotional wellbeing of their students would likely:

> initially be evident in family workforce participation and school engagement, but [would] persist for some years beyond the intervention, improving connections with community, outcomes from education and work, and ongoing mental health.[406]

At the Commission's human-centred design sessions, schools were raised an important source of support for young people with lived experience. Participants raised the need for more mental health training in schools.[407]

Schools and teachers also play a frontline role in 'identifying and supporting students with mental health issues at both primary and secondary schools'.[408] This puts them in a strong position to help to reduce the impact of poor mental health on students and their families, and would also likely reduce the proportion of students who become disengaged from school for mental health reasons.[409] One review suggested that:

> Not completing secondary school can limit employment options, lead to severe levels of disadvantage and increased burden on welfare and healthcare systems. All young people, including those in rural areas, have the right to education and should not be disadvantaged in their educational aspirations because they have an emerging or current mental illness.[410]

11.4.5 Snapshot of mental health initiatives in schools

There are several mental health and wellbeing frameworks and initiatives directed at children and young people through schools. These have been developed by both the Commonwealth and Victorian Governments, as well as non-government organisations.

Table 11.1 provides a snapshot of some of the programs and frameworks currently in place. The Commission recognises that this is not an exhaustive list of initiatives. There are many other programs that seek to support mental health and wellbeing as either a primary or secondary aim. Additionally, many areas of the Victorian curriculum are designed to support good mental health outcomes.

Table 11.1: Select examples of mental health programs and frameworks in education

	Program type		
Jurisdiction	**Government frameworks and mental health promotion programs**	**Mental illness prevention and early intervention programs, and teacher training**	**Treatment, care and support**
Commonwealth Government	*The Australian Student Wellbeing Framework* Be You—Commonwealth funded delivered by Beyond Blue		
Victorian Government	*The Victorian Early Years Learning and Development Framework* Resilience, Rights and Respectful Relationships Bullystoppers Mental Health Toolkit Enhancing Mental Health Support in Schools Safe Schools program Maroondah Positive Education Network	School Wide Positive Behaviour Support	Student Support Services for schools Doctors in Secondary Schools Mental health pilot program for primary school students Mental Health Practitioners in Secondary Schools
Non-government organisations	A number of externally provided programs covering: • Wellbeing (Smiling Mind, Cancer Council Victoria Achievement Program) • Anti-bullying (You can Do It! Education) • Mental health anti-stigma programs (batyr)	SAFEMinds Berry Street Education Model	headspace counselling for secondary students

Source: Commonwealth Department of Education, Skills and Employment, The Australian Student Wellbeing Framework, <www.education.gov.au/national-safe-schools-framework-0>; Beyond Blue, Be You, <beyou.edu.au/>; Orygen, University Mental Health Framework, <www.orygen.org.au/Policy/University-Mental-Health-Framework>; Department of Education and Training, Victorian Early Years Learning and Development Framework, 2016; Department of Education and Training, Resilience Rights and Respectful Relationships: Teaching for Social and Emotional Learning and Respectful Relationships, 2018; Department of Education and Training, Behaviour — Students: 5 School-Wide Positive Behaviour Support (SWPBS) Framework, <www2.education.vic.gov.au/pal/behaviour-students/guidance/5-school-wide-positive-behaviour-support-swpbs-framework>; Department of Education and Training, Bully Stoppers, <www.education.vic.gov.au/about/programs/bullystoppers/Pages/default.aspx>; Department of Education and Training, Mental Health Toolkit, <www.education.vic.gov.au/school/teachers/health/mentalhealth/Pages/mentalhealthtoolkit.aspx>; Department of Education and Training, Draft Enhancing Mental Health Support in Schools Initiative; Department of Education and Training, Safe Schools, <www.education.vic.gov.au/about/programs/Pages/safeschools.aspx>

Mental health and wellbeing is also a discrete focus area within the social and community health section of the Victorian school curriculum, across Years 3 to 10. The curriculum includes other relevant focus areas, such as alcohol and other drugs, health benefits of physical activity, and relationships and sexuality, which contribute to students' understanding of the broader influences on mental health.[411]

The curriculum develops students' knowledge, understanding and skills, enabling them to critically analyse contextual factors that influence the health and wellbeing of communities.[412] The content helps students access information, products, services and environments in order to promote the health and wellbeing of their communities.[413]

There are also several initiatives that seek to address factors related to mental health, such as social exclusion and trauma. For example, the Victorian Government implemented the Safe Schools program in 2010 to create more inclusive schools and to support the health and wellbeing of young people who are LGBTIQ+.[414] 'Queer–straight alliances' and 'diversity groups' that are formed in schools by young people who are LGBTIQ+ are good examples of initiatives that promote social connection, belonging and wellbeing.[415]

11.4.6 Mental health promotion programs in schools

Schools have an important role to play in fostering both the cognitive development and the social and emotional development of children and young people.[416] Whole-school and universal approaches include programs that are implemented within the curriculum and are focused on the social and emotional development of children and young people, rather than aimed at students who may be in need of specific supports or approaches.[417]

Where universal approaches target the whole classroom or student body, whole-school approaches are applied across the school and its community. They recognise that all aspects of the school community can have a positive impact on students' health and wellbeing. A whole-school approach provides students with exposure to key messages and learning tools across the curriculum, policies and practices of the school and school community.[418]

In 2011, a meta-analysis of 213 school-based, universal approaches focused on social and emotional development was conducted.[419] Programs reviewed in the meta-analysis involved 270,034 participants in kindergarten, primary and secondary school.[420] Participants who received these approaches demonstrated significantly improved social and emotional skills, attitudes, behaviour and academic performance compared with controls.[421] This review suggested that 'effective mastery of social-emotional competencies is associated with … better school performance whereas the failure to achieve competence in these areas can lead to a variety of personal, social, and academic difficulties'.[422] Similarly, research also supports the benefits of whole-school approaches in the area of health and wellbeing programs.[423]

However, some literature indicates that there are limitations in the impact of universal approaches in relation to the prevention of mental illness in young people.[424] The Prevention Coalition suggested that whole-school approaches may better succeed in preventing mental illness by integrating classroom-based mental health skill-building programs, including those that focus on anti-bullying.[425]

Resilience, Rights and Respectful Relationships

Resilience, Rights and Respectful Relationships is a Victorian whole-school approach that aims to help schools and early childhood settings promote and model respect, positive attitudes and behaviours. The program was introduced in response to a recommendation of the 2015 Royal Commission into Family Violence. In addition to respectful relationship modules, the program covers evidence-informed learning materials on emotional literacy, personal strengths, positive coping, problem-solving, stress management and help-seeking.[426] The Victorian Government has committed to implement this program in all schools and kindergartens by 2021.[427]

An evaluation, undertaken during 2017–18, indicated Resilience, Rights and Respectful Relationships is achieving change in the knowledge, attitudes and behaviours of school and early childhood educators related to the objectives of the program, and that similar changes are expected among children and young people in the near term as delivery progresses.[428] There was also evidence that increasing the alignment and linkages between Resilience, Rights and Respectful Relationships and broader school health and wellbeing initiatives would increase its impact.[429] The Commission suggests that future evaluations of the Resilience, Rights and Respectful Relationships assess elements that relate to social and emotional wellbeing in addition to respectful relationships.

The Commission supports the full and ongoing implementation of the Resilience, Rights and Respectful Relationships program. The Commission considers that this program provides foundational social and emotional wellbeing resources for school-aged children in all government schools and early childhood settings.

Maroondah Positive Education Network

The Maroondah Positive Education Network is a partnership between Maroondah City Council, the Maroondah Principals Network, the Department of Education and Training, the University of Melbourne and the Institute of Positive Education.[430] This network aims to increase the wellbeing and educational outcomes of students in Maroondah through the implementation of targeted positive education and wellbeing initiatives.[431] Positive education is described by the Institute of Positive Education as:

> a road map of what people want for themselves, their students, and their children: good health, frequent positive emotions, supportive relationships, a sense of purpose and meaning, the accomplishment of worthwhile goals, and moments of complete immersion and absorption—a life where a person uses their character strengths in ways that support the self and others, and that has flourishing at the heart.[432]

Since 2016, the schools participating in this network have made significant progress, through the development of a positive education network, the appointment and training of positive education leaders at each school, and the delivery of several wellbeing literacy initiatives in schools.[433] In 2018, funding was provided by the Victorian Government to advance the project in Maroondah and investigate the scaling of the work across the state.[434] The Commission encourages the Victorian Government to continue to explore the potential to scale this program.

Other programs

There are several universal programs that address the mental health and wellbeing of students, including anti-bullying and anti-stigma programs, some of which are reflected in Table 11.1.[435] A 2018 systematic review of school bullying-prevention programs indicated that these programs can reduce bullying by up to 20 per cent.[436] The Department of Education and Training has released a website called Bullystoppers, which supports teachers, principals, parents and students in working together to help put a stop to bullying.[437]

However, implementation of these programs is patchy, limited by resource constraints, competing demands and inadequate teacher training.[438] There is scope to address these issues and improve access by providing funding and guidance to schools so they can select the most appropriate program for their circumstances.[439]

11.4.7 Early intervention programs in schools

Other programs focus on early intervention and mental illness prevention and are more targeted than whole-school and universal approaches. These programs are aimed at population subgroups whose risk of experiencing poor mental health is significantly higher than average, and young people who are already exhibiting clinical symptoms.[440] These programs may complement whole-school and universal approaches. They are informed by evidence that certain risk factors can predicate the development of poor mental health, and as such, seek to keep this from happening.[441]

Berry Street Education Model

The Berry Street Educational Model focuses on developing strategies for teachers to increase engagement with students who have complex, unmet learning needs and improve their self-regulation, growth and academic achievement.[442] The model is based on trauma-informed and wellbeing practices that have been applied in mainstream and specialist schools. Mr McMahon explained that:

> This is about teachers developing understanding and having empathy for children's experiences of trauma and providing teachers with strategies for implementing a positive road forward. It enables teachers to teach within a social and emotional framework where trauma is the underpinning condition.[443]

School-wide positive behaviour support

School-wide positive behaviour support is an optional framework for Victorian schools that brings together school communities to develop positive, safe, supportive learning cultures. It helps schools identify and successfully implement evidence-informed practices to enhance social, emotional, behavioural and academic outcomes for children and young people.[444]

The framework utilises a multi-tiered system of support, with universal primary prevention approaches, coupled with selective and indicated approaches for students demonstrating at-risk behaviour.[445]

11.4.8 Treatment, care and support in schools

Mental Health Practitioners in Secondary Schools

Mental Health Practitioners in Secondary Schools provides support to young people exhibiting symptoms of mental distress.[446] The Victorian Government has committed that every secondary school campus will have a suitably qualified mental health practitioner by the end of 2021. Allocation of mental health practitioners is based on student enrolments, with each campus receiving 0.5 fulltime-equivalent on average.[447] In its submission, Beyond Blue supported this initiative as a positive investment in mental health in schools.[448] The Victorian Government has identified it as a priority mental health reform.[449]

The practitioners will work to the needs and priorities of schools, and coordinate support for students with mental health needs with the existing Student Support Services, headspace centres and whole-school prevention and mental health promotion approaches.[450] The Commission supports the Victorian Government's full implementation of the Mental Health Practitioners in Secondary Schools program by the end of 2021.

Mental health pilot program for primary school students

A mental health pilot program for primary school students is currently being piloted in 10 Victorian primary schools, providing school staff with evidence-based training and resources to help them better identify and respond to mental health issues affecting primary school students.[451] In August 2020, it was announced that the program would expand to an additional 15 schools.[452]

The intention of the program is to build strong connections between participating schools and community-based health services, so that students and their families can be linked to these services when needed.[453] Should this pilot prove to be effective, the Commission encourages the Victorian Government to extend the pilot to more schools.

Student Support Services

The Commission recognises the value of Student Support Services teams. Student Support Services is an established program in Victorian schools that helps children and young people who are facing barriers to learning to achieve their educational and developmental potential.[454] Student Support Services comprises a broad range of professionals, including psychologists, speech pathologists and social workers.[455] The Commission encourages the Victorian Government to continue to support these teams.

headspace

Secondary students attending Victorian Government schools who are 'experiencing mild to moderate mental health issues' can access face-to-face and telephone counselling services from headspace centres located across Victoria.[456] In March 2020, the Commonwealth Government announced that headspace will receive an additional $6.75 million to support its Work and Study Program for young people, providing a comprehensive national digital support service for all young Australians during the COVID-19 pandemic and after.[457] The Commission supports the headspace in schools programs.

11.4.9 Helping schools to select and tailor initiatives

The range of mental health and wellbeing frameworks and initiatives directed at children and young people causes some confusion for schools and an inconsistent application of efforts across Victoria.[458] Victorian Government schools have high levels of autonomy, with decentralised hiring and management of staff professional development.[459] The Victorian Government's submission to the Commission stated that:

> while Victoria has frameworks for supporting health and wellbeing, including explicit teaching of social and emotional wellbeing skills for children and young people, these are inconsistently applied in early childhood and education settings across the state.[460]

The Commission has also heard that there is a need for a broader range of mental health programs to promote mental health and wellbeing of infants, young children and young people outside of those existing within early education settings.[461]

In its Consensus Statement, the Prevention Coalition identified the positive impact of mental health and wellbeing initiatives on students, particularly those that promote life skills and address bullying.[462] The Consensus Statement called for the development of an accreditation system for evidence-informed initiatives.[463] It also highlighted the need for more resources so that schools can purchase program licences or support the professional development of staff.[464] It identified that the current application of initiatives by schools is patchy, and that more support from government is required.[465] According to a New South Wales Department of Education review of the evidence of anti-bullying initiatives in schools, schools need support to identify which interventions are likely to be most successful based on their specific contexts and requirements.[466]

School Readiness Funding, described in Box 11.3, informed the Commission's recommendations aimed at helping schools navigate and select initiatives according to their priorities.

Box 11.3: School Readiness Funding

School Readiness Funding, a Victorian Government initiative, aims to build the capacity of 'kindergarten services, educators and families to support children's learning and developmental outcomes'.[467] The program commenced in 2019,[468] with full roll-out to all funded three-year-old and four-year-old kindergarten services expected by 2021.[469] The program is ongoing and is in addition to Commonwealth funding.

The amount of School Readiness Funding each service receives is 'based on the level of need of the children enrolled at the service, [t]his is informed by parental occupation and education data', which is 'considered an accurate predictor of educational disadvantage'.[470]

Funding for each service ranges from $1,000 to more than $200,000 for kindergartens depending on level of need and enrolment numbers.[471] 'Kindergartens are able to choose from a menu of evidence-informed programs and supports to spend their funding on'.[472]

Services are required to spend most of their funding on items within the program's three priority areas:

- 'communication (language development)
- wellbeing (social and emotional) and
- access and inclusion'. [473]

The menu describes 'a range of initiatives and supports that have been externally validated for how well they support children's learning and development'.[474] The menu helps kindergartens make 'informed choices on how to spend their funding to improve outcomes for children'.[475] It includes:

- 'programs and services that target speech, language and literacy
- allied health supports (speech pathologists, psychologists, occupational therapists)
- programs and services that inform educators and families about trauma-informed practice, secure attachment and mental health
- resources and programs to improve the social and emotional wellbeing of children
- support for culturally and linguistically diverse children, and families
- tools for parents to support their child's development.'[476]

Approved service 'providers submit an annual School Readiness Funding Plan for each of their managed services', drawing on local and service-level data to determine the needs of each service.[477]

Kindergartens are encouraged to partner and pool their funding where there is a shared interest.[478]

11.4.10 Supporting Mental Health and Wellbeing in Schools

There is compelling evidence before the Commission demonstrating the positive role schools can play in promoting social and emotional wellbeing and intervening early in poor mental health. Recognising the high number of children and young people engaged in education settings, the Commission concludes that education settings have a critical role in supporting the mental health and wellbeing of Victorians.

The Commission recommends the development and implementation of an approach to enable primary and high schools across Victoria to identify and access a range of resources, guidance materials and evidence-informed programs and initiatives that support the mental health and wellbeing of their students. These resources, programs, materials and initiatives will be validated against a set of criteria agreed by the Department of Education and Training, in partnership with the Mental Health and Wellbeing Division of the Department of Health and the Mental Health and Wellbeing Promotion Advisor. The Commission also recommends the development of a digital platform that will include a navigation function to make it easy for schools to select the most appropriate initiatives and guidance for them.

The development of this approach should be guided by a reference group with membership from the consumer advocacy function of the Mental Health and Wellbeing Commission, the Chief Mental Health and Wellbeing Officer, senior representatives from the Department of Education and Training, principals, teachers, students, parents and mental health in-school practitioners (such as primary welfare officers, Student Support Services and primary school nurses). Like the School Readiness Funding initiative, annual and ongoing funding should be available to all primary and secondary schools to support them to select and implement mental health and wellbeing supports, based on level of need.

Where there are gaps, and with particular consideration given to schools in rural and regional Victoria, the Department of Education and Training should fund the development of additional initiatives to be made available to schools. To fairly allocate this funding and ensure it achieves maximum benefit, the Department of Education and Training will develop a needs assessment tool to determine how much funding each school receives, based on enrolments and the level of need of those enrolled in the school, informed by data that predicts disadvantage.[479] In developing this approach, funding priority should be given to rural and regional areas, in recognition of the higher reported incidence of poor mental health and higher rates of suicide and addiction in these areas.[480]

The Commission advises that the total funding envelope for this initiative should reflect the Commission's emphasis on the critical role that schools can play in supporting mental health and wellbeing, and the significant opportunity to improve mental health outcomes for children and young people now and into the future. This position was also recently supported by the Productivity Commission.[481] Noting that funding of $160 million was provided (over four years) for the School Readiness Funding initiative,[482] the Victorian Government should consider this allocation as a relative guide in developing its approach to the extension of support for the mental health and wellbeing of all primary and secondary school students.

Schools will be able to choose the programs that best suit their needs via a digital platform established by the Department of Education and Training. The platform will aim to improve the ease with which schools can identify evidence-informed programs and seek guidance for the delivery of teaching and learning in the area of mental health and wellbeing. The platform will feature a list of validated, evidence-informed resources, programs, materials and initiatives focused on mental health and wellbeing, including:

- whole-school and universal approaches focused on social and emotional wellbeing
- initiatives that address specific issues such as bullying, cyber-bullying and mental health stigma
- initiatives to address racism and discrimination
- teacher training relating to mental health and wellbeing
- selective and indicated approaches
- individual services for students who need more help with their mental health and wellbeing.

The platform will also provide user-centric navigation and guidance in relation to:

- the level of evidence supporting the program
- the target group for the program/age level
- delivery information, such as delivery mode
- program cost.

The platform may also promote existing frameworks and whole-school approaches, such as the Resilience, Rights and Respectful Relationships initiative, and school-wide positive behaviour support, and provide options for additional implementation support. It is expected that the Victorian Mental Health Toolkit[483] and the Be You[484] initiatives directory will inform this approach. The platform should also list validated initiatives available through other sources, such as the Commonwealth Government or non-government organisations.

Schools will submit an annual plan to the Department of Education and Training, describing the school context and mental health and wellbeing needs and requesting funding for identified initiatives from the platform. It is expected that primary schools receive a higher funding range than secondary schools, given that secondary schools currently have additional mental health supports available to them.

It is proposed that this reform will improve access to initiatives for students, teachers and school communities, and provide greater consistency of support across the state. Navigation assistance will help schools make informed choices about which initiatives will best suit their circumstances. This will also support school autonomy and implementation flexibility.

There should also be a public-facing platform for families, carers and supporters, so they can have access to information and resources to help them support the mental health and wellbeing of students.

As described in detail in Chapter 19: *Valuing and supporting families, carers and supporters*, the Commission recommends that the Department of Health partners with the Department of Education and Training to explicitly build young mental health carers into initiatives focused on the mental health and wellbeing of students. Through the development of the navigation tool and associated validation of initiatives, the Department of Education and Training should consider how these initiatives will cover young mental health carers, including opportunities for early identification and raising awareness of the needs of young carers.

The digital navigation tool should also list treatment, care and support services available to government schools in the area, including services offered by schools themselves, through Student Support Services and other initiatives.

The Productivity Commission's *Mental Health Inquiry Report* contains a recommendation titled 'Focus on children's wellbeing across the education and health systems'.[485] The Productivity Commission recommends that governments should update the National School Reform Agreement to include student wellbeing as an outcome for the education system, with measurable targets.[486] Specifically, the Productivity Commission recommends teacher education and professional development initiatives.[487]

The Royal Commission's recommended approach aligns with and complements the Productivity Commission's recommendation. The Productivity Commission also proposes that governments should consider the establishment of special purpose grants to help early childhood education and care services support children's social and emotional development. These grants, if supported by the Victorian Government, would fund the initiatives selected through the navigation tool that will be established for schools.

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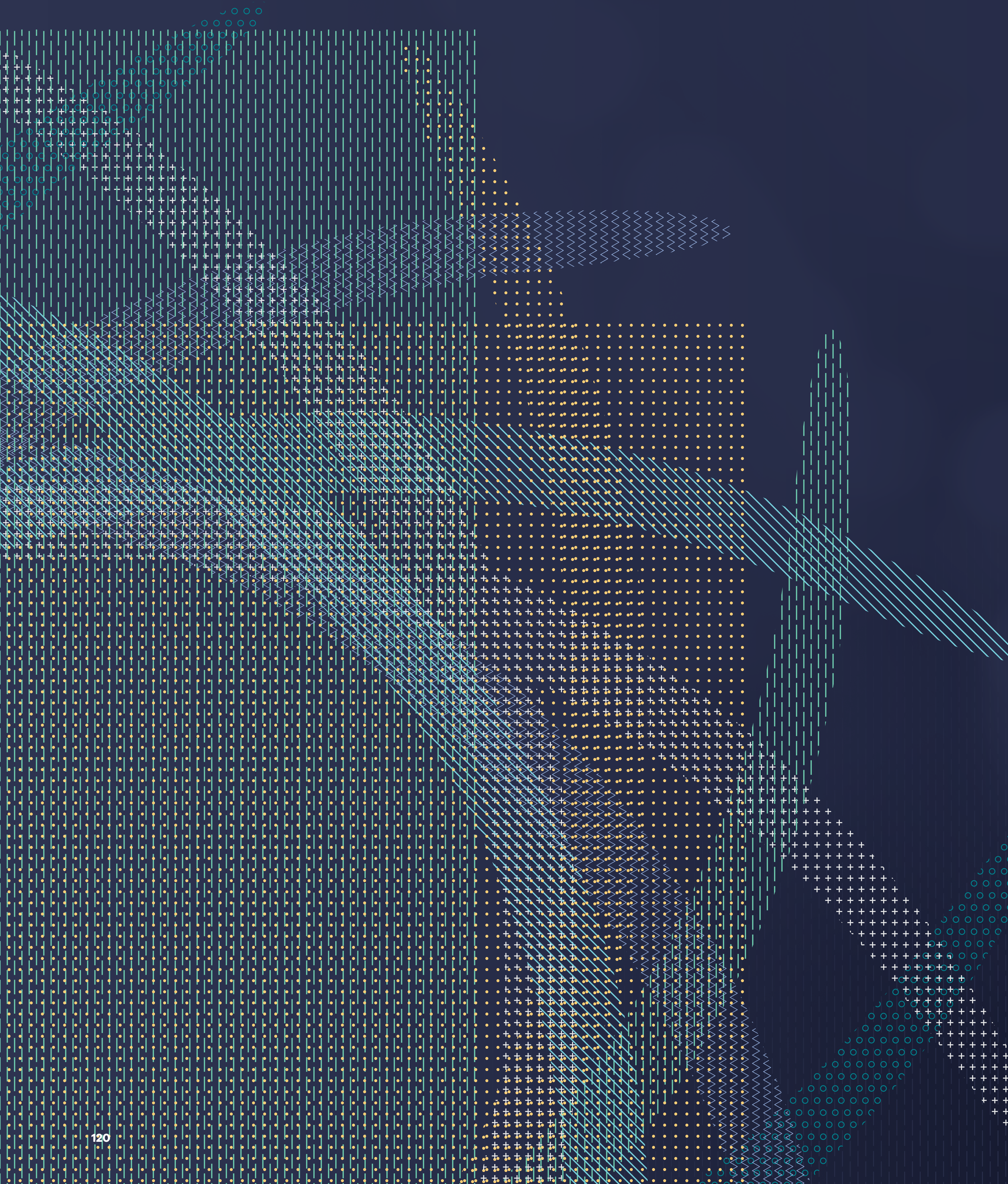


Chapter 12

Supporting perinatal, infant, child and family mental health and wellbeing

Recommendation 18:

Supporting the mental health and wellbeing of prospective and new parents

The Royal Commission recommends that the Victorian Government:

1. expand and reform the community perinatal mental health teams in each Adult and Older Adult Area Mental Health and Wellbeing Service across Victoria to adapt and deliver the core functions as set out in recommendation 5, including by providing consultation to primary and secondary care and related services for prospective and new parents, including maternal and child health nurses.
2. review approaches to perinatal mental health screening.

Recommendation 19:

Supporting infant, child and family mental health and wellbeing

The Royal Commission recommends that the Victorian Government:

1. establish one responsive and integrated infant, child and youth mental health and wellbeing system to provide developmentally appropriate mental health and wellbeing treatment, care and support for newborns to 25-year-olds.
2. by the end of 2022, establish a dedicated service stream for infants, children and their families, consisting of Infant, Child and Family Area Mental Health and Wellbeing Services, within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(c)) to:

   a. provide developmentally appropriate mental health and wellbeing treatment, care and support services for newborns to 11-year-olds and their families; and
   b. adapt and deliver the core functions of community mental health and wellbeing services (refer to recommendation 5), including through a range of delivery modes, ensuring services are accessible and responsive to the diversity of local communities.

3. by the end of 2022, and in partnership with the Commonwealth, establish three infant, child and family health and wellbeing multidisciplinary community-based hubs.
4. deliver evidence-informed online parenting programs and group-based parenting sessions.
5. establish two statewide subacute residential family admission centres located in the community.

12.1 Mental health and wellbeing challenges early in life

Many people spoke to the Commission about the importance of strengthening the treatment, care and support available to people experiencing mental health and wellbeing challenges early in their lives. This chapter considers the mental health and wellbeing of prospective and new parents and the youngest Victorians—infants and children up to 11 years of age, as well as their families, carers and supporters.

The right treatment, care and support, delivered compassionately and as soon as mental health and wellbeing challenges emerge, can be life-changing for the individual and their family, carers and supporters. Conversely, when this treatment, care and support is difficult to access or not offered in a timely way, the consequences can be significant for the infant or child and their family, carers and supporters. One person told the Commission:

> getting children the help they need is incredibly difficult when it seems to be based on an old model/one that is purely based on where you live and how the funding is allocated. The children's and adolescent mental health system is very difficult to navigate and people become disheartened trying to battle to get services for their loved ones.[1]

An investment in perinatal and infant and child mental health and wellbeing has the potential to improve the trajectory of the mental health and wellbeing of future generations and reduce future demand for youth and adult and older adult mental health and wellbeing services. It could also help to address a range of social issues, with research suggesting that crime, poor education outcomes and unemployment can often be traced back to adverse experiences in the early years.[2]

Infant and child mental health and wellbeing clinicians, service providers and academics urged the Commission to make mental health and wellbeing challenges that occur early in life a priority. For example, the Australian Medical Association (Victoria) stressed that '[i]ntervention early in life is very important but also critically, intervention early in the development of mental illness can reduce its impact on health and wellbeing across the lifespan.'[3]

The predominant focus of the current system is on mental health and wellbeing challenges that occur in young people and adults, with relatively fewer resources allocated to perinatal, infant and child mental health and wellbeing. This imbalance needs to be redressed so that access to contemporary treatment, care and support does not depend on age, and opportunities to change the trajectory of mental health and wellbeing challenges are harnessed.

Many stories shared by parents have inspired the Commission's reforms. While some had experienced compassionate, high-quality mental health and wellbeing treatment, care and support that was available when they needed it, far too many did not. Too rarely were families that asked for help met with a timely, compassionate response of—'How can we help?'

Some parents spoke of difficulties in navigating the system, of being told they or their child were not sick enough to meet the entry threshold for a service, or that they were too sick and had to be referred to another service. Others spoke of long wait times and sometimes stigmatising responses that conveyed judgement about their parenting abilities and left them reluctant to ask for help again.

Some parents spoke of the fear that seeking help for mental illness or psychological distress may risk their children being removed from their care.

Many spoke of the devastating effects on the child, parents, siblings and families, carers and supporters when help was not provided. The Commission also heard of the effect of mental health and wellbeing challenges on other areas of development, such as positive attachment relationships and successful transitions into early education and primary school. Ms Erin Davies, a witness before the Commission, whose son has received treatment, care and support in the mental health system since he was in Grade 1, commented that:

> He's developing and maturing, in spite of the mental health system. In my view the system has done nothing to help him; it has traumatised him and our family. In spite of that, he's able to get up and go to school.[4]

The need for reform is clear. An emblematic feature of Victoria's future mental health and wellbeing system will be an emphasis on, and investment in, mental health and wellbeing challenges that occur early in life. Early intervention, which is providing treatment, care and support when mental health and wellbeing challenges first present, rather than waiting for the challenges to intensify,[5] is at the heart of this investment. Professor Louise Newman AM, Professor of Psychiatry at the University of Melbourne and a practising perinatal and infant clinician, told the Commission:

> Given the current mental health system is overwhelmed by acute presentations and crisis responses, we cannot afford to have a system that is not informed by the science of early intervention.[6]

12.1.1 A new direction for perinatal, infant and child mental health and wellbeing

The Commission's vision for Victoria's future mental health and wellbeing system includes providing responsive and integrated treatment, care and support for prospective and new parents and for infants and children up to 11 years of age. Victoria will have an evidence-based, contemporary system of treatment, care and support where parents, infants and children with mental health and wellbeing challenges are welcomed and treated compassionately.

The time around the birth of a child is one of life's most important stages, but at the same time, is also a high-risk period for mental health and wellbeing challenges. Accordingly, the Commission's reforms across the perinatal, infant and child life stages outlined first in this chapter begin with treatment, care and support for people with perinatal mental illness so they are better supported to recover at this crucial time of their lives. As a major reform, perinatal mental health clinicians and support workers based in all Adult and Older Adult Area Mental Health and Wellbeing Services will be available for people in the early stages of their mental health and wellbeing challenges. They will provide evidence-based treatment, care and support to help prospective and new parents to remain in their homes, focused on building strong relationships with their infant.

This focus on early life will continue in section 12.4 of this chapter, which describes investments in early intervention for infants and children who are experiencing emotional, developmental or behavioural challenges.

New partnerships to provide treatment, care and support will be formed between different parts of the system so that infants and children can be better supported in the places they live, learn and play. These new partnerships include shared care arrangements between infant and child clinicians in Infant, Child and Youth Area Mental Health and Wellbeing Services and GPs, paediatricians and enhanced maternal and child health nurses.

Supports for parents, carers and supporters in their important caring roles will also be introduced across the system for the first time, and there will be a culture of respecting and involving families, carers and supporters in treatment, care and support.

Chapter 4: *Working together to support good mental health and wellbeing* also describes how the future system will include prevention strategies that address the social determinants of mental health and wellbeing, including for infants and children and their parents, carers and supporters. It outlines future approaches to mental health and wellbeing promotion activity in the places and environments that influence young children and families, such as early learning centres, primary schools and sports and other recreation settings.

This chapter outlines the Commission's reforms to perinatal and infant and child services. It begins at conception and continues through infancy and childhood, concluding at 12 years of age, which typically coincides with the transition from primary school to secondary school. The chapter that follows, Chapter 13: *Supporting the mental health and wellbeing of young people*, focuses on the youth mental health and wellbeing service stream, which begins at a young person's 12th birthday and continues until their 26th birthday.

Combining perinatal and infant and child mental health and wellbeing in the same chapter was a deliberate choice that reflects the importance of the parent–child relationship.

This chapter builds on the concepts, principles and directions outlined in Chapter 5: *A responsive and integrated system* and Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. These chapters outline in detail the reforms that underpin the Commission's design of Victoria's future mental health and wellbeing system, which has then been adapted for infants, children and families, as explained in this chapter.

12.2 Perinatal mental health and wellbeing

12.2.1 Mental illness and psychological distress in the perinatal period

While there are several definitions, the Commission uses the term 'perinatal mental health' to refer to the mental health of a prospective or new parent and their infant from conception until 24 months after birth.[7] It includes both parental mental health and the health of the unborn infant or young infant, and the developing parent–infant relationship.[8]

As well as being a major transition point in life, the perinatal period is one of high risk to mental health and wellbeing. Poor mental health and wellbeing can start, recur or get worse during the perinatal period.[9]

Experiences of mental illness or psychological distress during the perinatal period vary widely, although research into its prevalence tends to focus on specific diagnoses. For example, perinatal depression appears to be relatively common. A 2010 Australian survey of 4,366 women identified that 17 per cent (approximately one in five) had experienced postnatal depression by six months after birth.[10] A 2018 Australian study of 9,962 women indicated 11 per cent (approximately one in 10) had experienced antenatal depression—that is, before birth.[11] The 2010 Australian National Infant Feeding Survey suggested that the prevalence of perinatal depression in Victoria (10.7 per cent) was similar to the national average (10.0 per cent).[12] Perinatal anxiety is even more common, with research suggesting that around one in five women in both the antenatal and postnatal periods will experience perinatal anxiety.[13]

Although much rarer, research estimates that one to two of every 1,000 new mothers will experience postnatal psychosis.[14] Postnatal psychosis can be a 'potentially life-threatening condition that can put both mother and baby at risk' and requires urgent medical assistance and almost always a hospital admission for specialised treatment.[15] The early detection of postnatal psychosis is critical and timely access to specialised treatment, care and support at parent and infant units is essential.[16] Unfortunately, without access to timely and suitable treatment, care and support, postnatal psychosis can have 'sometimes tragic consequences'.[17]

Concerningly, for some women, the risk of suicide can also be heightened in this period. The 2018 *Victoria's Mothers, Babies and Children* report stated that suicide was the leading cause of maternal deaths in Victoria between 2016 to 2018.[18]

There is generally less research on the prevalence of perinatal mental illness among fathers and non-birth parents. However, one Australian study estimated that approximately one in 10 fathers will experience postnatal depression.[19]

Perinatal mental illnesses can arise from a combination of biological, sociological and psychological factors.[20] Factors can include a lack of partner or social support, a history of mental health problems, previous trauma and stressful life events.[21] These experiences can be entirely new, they can be the return of previous perinatal mental illness or they can emerge alongside existing mental illnesses during a pregnancy.[22]

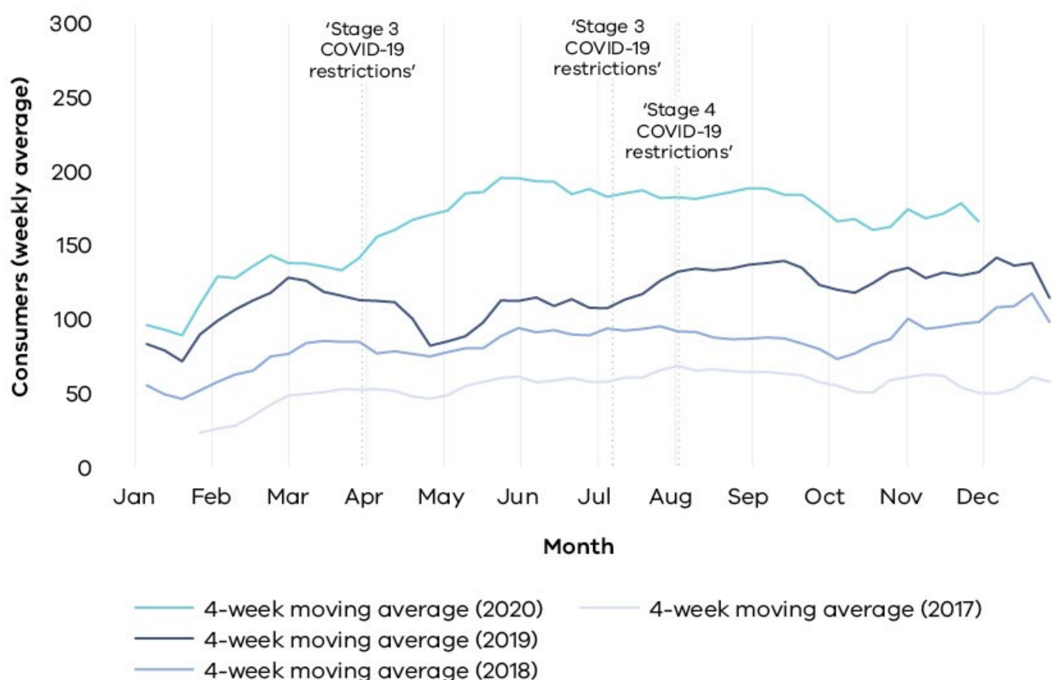
Mental health and wellbeing challenges in the perinatal period arise at a stage in life that society generally associates with happiness. This can add complexity for new parents, in addition to the need to physically care for the infant, and potentially other children. Perinatal Anxiety & Depression Australia (PANDA) submitted that many people had spoken of the impact of having a mental illness or experiencing psychological distress while pregnant or a new parent:

> There were many tears … lots of times of doubting myself, seeing myself as worthless, seeing myself as never good enough and wanting to sometimes pack up and leave, or not be on earth anymore. I still have days that I cry, that I can't cope, or I can't handle a situation. I am still seeing a psychologist, and still on medication.[23]
>
> I experienced terrible anxiety during my first pregnancy, which was never discussed. The birth of our first child was traumatic, it was never followed up on or discussed. And then after our second child was born anxiety was very present yet there was no one I felt I could turn to or ask for help. The stigma of feeling I was 'failing' was overwhelming.[24]

Research suggests that mental illness or psychological distress can interfere with a person's adjustment to parenthood and affect their ability to care for their newborn baby and other children.[25] The disruption of parent–infant relationships this early in life can also have an adverse impact on the infant's development, cognition, behavioural outcomes and attachment relationships.[26]

Other major life disruptions can add an additional layer of strain. In Victoria in 2020, the COVID-19 pandemic and rules around lockdowns and physical distancing meant new parents were isolated in their homes, limiting the level of support they might usually experience during the perinatal period. This is reflected in the increased provision of services throughout 2020 by the Victorian Government–funded Perinatal Emotional Health Program, delivered by area mental health services, as shown in Figure 12.1.

Figure 12.1: Number of registered consumers receiving a contact from the Perinatal Emotional Health Program, Victoria, 2017 to 2020



Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2017 to 2020.

Notes: Stage 3 COVID-19 restrictions: Implemented on 30 March 2020 and again on 8 July 2020 for metropolitan Melbourne, and allowed people to leave their home for only four reasons: work, caregiving or receiving, exercise and shopping for essential goods and services.

Stage 4 COVID-19 restrictions: Implemented on 4 August 2020, and in addition to the restrictions under Stage 3, additional restrictions limited travel to up to 5 kilometres from a person's home for necessary goods and services. Only one person per household could leave home to shop once per day. Curfews were in place from 8:00 pm to 5:00 am every night to reduce the number of people leaving their homes and moving around.

Refer to Volume 5, Appendix B for additional information regarding COVID-19 restrictions in Victoria.

12.2.2 Victoria's current perinatal mental health services and their challenges

Parents can access treatment, care and support for perinatal mental illness in many different ways. As well as support from their own families, carers and supporters, they can also access information on websites and apps designed for parents.

Many organisations are funded to support people with perinatal mental illness, including PANDA, which operates a national helpline and online forums.[27] Parents can join various online and local communities, including peer-led groups.

The Victorian Government has also funded a network of seven early parenting centres.[28] These centres support the mental health and wellbeing of parents and infants through their role in 'nurturing baby/parent interactions, through sleep, play and love to build stable, secure individuals, families and communities'.[29] Ms Jacquie O'Brien, CEO of Tweddle Child and Family Health Service, stated that families often present with sleep issues, but as families build trust with clinicians and workers at the early parenting centres, they start to talk about their mental health and wellbeing:

> They're coming to us with babies [that] don't settle, but it is far more than that. [We are] a lovely soft entry into a system that can do some work in joining up different parts of the system to help families. 70 per cent of families coming into residential and [day programs] have high levels of depression and anxiety .... they often present with the baby that won't sleep, but the baby won't sleep because something else is going on ...[30]

Primary and secondary services also support people with perinatal mental illness. In particular, GPs undertake perinatal mental health screening, directly support women and men and are a key referral point when more specialised help is needed. Many GPs offer shared-care arrangements for maternity care, and regular appointments for maternity care provide important opportunities to support mental health and wellbeing. Private psychologists and psychiatrists also provide support, where available, and some specialise in perinatal mental illness.

Some consumers spoke of positive experiences in accessing treatment, care and support from primary and secondary services, while others spoke of their distress in not being acknowledged or helped in a way that was beneficial. One consumer said:

> When I developed perinatal anxiety ... my own GP said I wasn't depressed, but then his colleagues declared that I was. The psychologist he referred me to said it wasn't her role to be nonjudgmental. It was a really stressful time for me.[31]

The maternal and child health service is also a source of support for those experiencing perinatal mental illness. The service is funded by the Victorian Government as a free primary health service for all families with children from birth to school age.[32] Although the service focuses on child development, maternal and child health nurses undertake postnatal depression screening and can connect parents to specialised perinatal mental health and wellbeing services. The Victorian Government funds PANDA to support maternal and child health nurses to identify and refer parents at risk of, or experiencing, perinatal mental illness.[33]

Maternal and child health nurses often establish strong relationships with families through repeated interactions as the child grows. PANDA stated that 'helpline data [shows] that women residing in Victoria are more likely than those residing in other states to have shared how they have been feeling with their maternal and child health nurse'.[34] However, the Commission heard from maternal and child health nurses that once they have identified that a new parent is experiencing mental health and wellbeing challenges, connecting them with specialist perinatal mental health and wellbeing services can be difficult.

One maternal and child health nurse said:

> So, the nurse might be able to identify that there's a need, but the ability to be able to access the services that are required, sometimes that's not as available. And particularly in regional and rural areas. I think access is an issue to services and I think the other thing is that ... the level of disturbance or the level of need, has to be fairly high to access a lot of these services and there's a shortfall in the middle when we're starting to see things unravel for a family.[35]

Maternity services (both public and private) also provide support to prospective parents experiencing perinatal mental illness. For example, in accordance with the *National Clinical Practice Guidelines: Pregnancy Care (2019 edition),* mental health screening is part of routine antenatal (before birth) care at the 54 public health services that provide planned maternity and newborn care in Victoria.[36]

For consumers with the most complex support needs in relation to their perinatal mental health and wellbeing, the Victorian Government provides limited funding to adult area mental health services to deliver the previously mentioned Perinatal Emotional Health Program, which provides care in the community through mainly clinic-based appointments.[37] Clinicians, service providers and academics told the Commission about the limited capacity of the Perinatal Emotional Health Program teams compared with demand for the program. For example, Goulburn Valley Health said that:

> We used to run a highly successful model of the Perinatal Emotional and Mental Health Program that could no longer continue in its original form due to funding pressures.[38]

Ms Lynne Allison, Associate Program Director of Eastern Health's, Child and Youth Mental Health Service, also observed Eastern Health's limited capacity to provide community-based care:

> [T]he level of funding [from the then Department of Health and Human Services] does not enable the service to provide an adequate level of support. The service is a small clinical team (with approximately 3.5 EFT) against approximately 4,800–4,900 births delivered annually at Eastern Health sites, not inclusive of women within the region delivering privately, or in hospitals outside of the Eastern Region. Consequently, the service is currently limited to women birthing at Box Hill Hospital only ... The service is also unable to provide a crisis response, outreach, group programs and ... cannot accept post-natal referrals.[39]

Despite the limited availability of specialised perinatal mental health clinicians and support workers, evidence indicates that community-based care can be more effective than inpatient care for parents experiencing mental health and wellbeing challenges in the perinatal period. For example, research undertaken by the National Mental Health Commission in 2014 suggested that the number of days in a mother–baby unit for a person with severe postnatal depression could be more than halved if substituted for a combination of more home visits from GPs, psychologists, psychiatrists and community mental health teams, as well as group therapy and day patient services.[40]

However, there is still a need for inpatient treatment, care and support for a small number of women with the highest support needs, especially as they relate to postnatal psychosis. Victoria's six highly specialised parent and infant units provide a residential environment for women experiencing significant mental health challenges in the postnatal period, along with their infants aged up to 12 months.[41]

As the 2018 Victorian Parliamentary Inquiry into Perinatal Services described, 'these facilities allow for the baby to stay with the mother in her room, thereby assisting in the development of parenting skills and a positive relationship with the baby'.[42] In a Commission-led focus group, one mother shared her positive experience in a public parent and infant unit:

> it was a really good experience … the level of support that you get in there, and the attention and just all that empathy, it just made me such a better mum. And it just gave me so much confidence and a sense of identity that I obviously had lost.[43]

There are currently 33 operational beds in the six public parent and infant units,[44] noting that there are also several private providers of parent and infant units in Victoria. In 2019–20, 440 consumers received assessment and support in one of Victoria's six parent and infant units.[45] The average length of stay in 2019-20 was 18.8 days,[46] and the most common diagnoses for consumers admitted to the units were major depressive disorder (24.8 per cent), anxiety disorders (19.6 per cent) and postnatal depression (17.3 per cent).[47]

In considering perinatal mental health services at the broadest level, the Commission heard that although Victoria was once considered a leader in perinatal mental health, more recently the effectiveness of its perinatal mental health services has declined. For example, the Australian Medical Association (Victoria) said that:

> Victorian perinatal services have undergone a significant decline over the past decade, despite international recognition of their importance. Many psychiatrists are aware that they will no longer be able to access the team-based supports and parent-infant beds when needed, when they accept a referral of a mother with a major mental illness. No-one would accept not treating other health complications such as gestational diabetes, premature labour or pre-eclampsia, which are also potentially life-threatening to the mother and baby.[48]

The Inquiry into Perinatal Services also found that Victoria's perinatal mental health services tend to act in isolation and that they need to be better integrated with general perinatal health services.[49]

The personal story from Cat Garcia highlights how a consumer can be appropriately supported by PANDA's helpline, a maternal and child health nurse, a GP and a psychologist.

Personal story:

Cat Garcia

Cat is 34 years old and the mother of three children. The birth of Cat's first child was a traumatic experience.

> It was a very intense and scary time. I had a massive haemorrhage and ended up needing two units of blood.

Cat had lost her own mother a few years before and said she did not realise how much her loss would affect her once she became a mother herself.

Cat said she was lucky that she had a good maternal and child health nurse who mentioned that having had a difficult birth, recently losing a loved one and having gone through cancer treatment, Cat had a higher probability of developing postnatal depression. The maternal and child health nurse left Cat with a booklet of information about postnatal depression.

Cat said that in those first few weeks after the birth she was looking out for the signs of postnatal depression.

> I didn't really feel depressed. I didn't feel down after the first few days. I just noticed that I didn't really want to go out in public or go to mother's group. I didn't want to get out of the house, and I was getting irritable and anxious.

It wasn't until Cat's daughter was a couple of months old that she decided to call PANDA's helpline.

> They were the ones that just brought the awareness to me that perinatal anxiety actually existed. They let me know that postnatal anxiety is more common than postnatal depression, but nobody really knows of it or talks about it.

Cat followed up with her GP, who gave her a mental health care plan and recommended that she speak to a psychologist. Cat was referred to a specialist perinatal psychologist located at the maternal and child health centre, which Cat said was a convenient and comfortable environment. Cat said that, at the time, this support was enough for her.

> I got to talk about everything I was feeling, started to feel a lot better and more confident in myself. I used all my 10 sessions. Knowing I could talk it through with somebody definitely helped me recover.

A couple of years later, Cat had her second child and said she was more aware of what to look for. She suffered postnatal anxiety but said she was well supported by her GP and psychologist. Cat was surprised that following the birth of her third child she did not experience the same challenges.

> It was strange to me because I was expecting it to happen again. Maybe I was a bit more relaxed after having two kids, but he was a different baby as well—slept a lot more and would settle a lot easier.

Cat says her anxiety remains in the background but is manageable now. She believes that every new mother should be given more detailed information about how she might feel after the birth of a child, rather than just a phone number to call. Cat said that parents may not recognise the feelings of anxiety and depression, and antenatal classes could provide a good opportunity to provide this information.

Cat is now a PANDA Community Champion and actively promotes awareness of postnatal mental health.

Source: RCVMHS, *Interview with Cat Garcia*, November 2020.

12.3 Victoria's future services providing treatment, care and support for perinatal mental health and wellbeing

Victoria's future services providing treatment, care and support for perinatal mental health and wellbeing are conceptualised within a responsive and integrated system that underpins the Commission's whole-of-system design as described in Chapter 5: *A responsive and integrated system* (refer also to Figure 12.2).

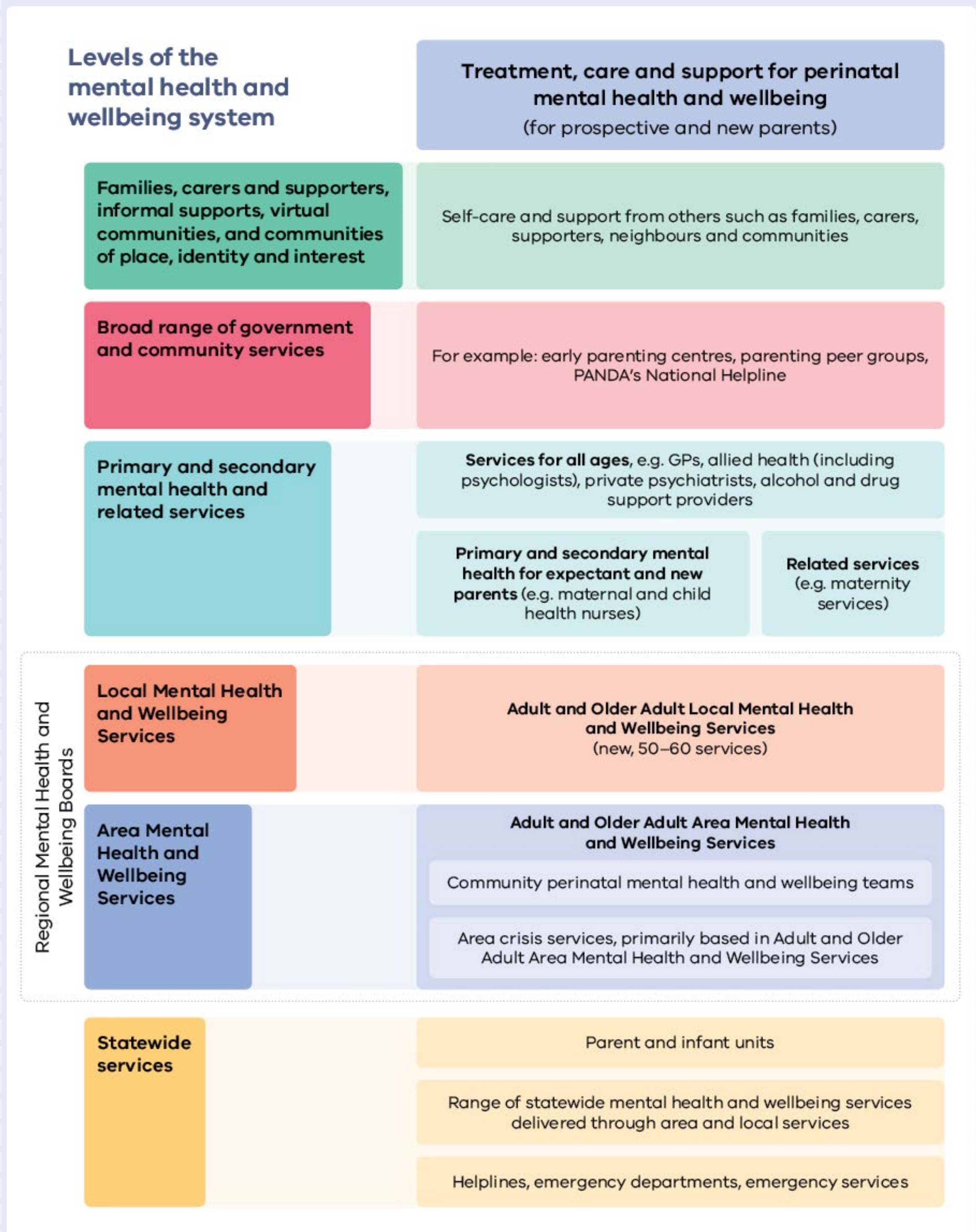
A responsive and integrated system enables treatment, care and support to be provided proportionate to people's needs, strengths and individual situations. It also facilitates a system of care forming around prospective or new parents as their needs change, with coordinated transitions between the levels of the system. Victoria's future services providing treatment, care and support for perinatal mental health and wellbeing will continue to encompass a range of services—funded by state and Commonwealth governments, as well as non-government organisations.

As described in Chapter 5, the premise of this system is that the initial levels will help the most people, with fewer people assisted at each subsequent level. The specialisation of mental health and wellbeing clinicians and support staff at each level increases so the treatment, care and support that prospective and new parents can access is proportionate to their situation, and the complexity of their needs.

The levels within the integrated system are not mutually exclusive—people with the highest support needs are still likely to benefit from supports at earlier levels, such as PANDA's national helpline and perinatal mental illness apps.

As described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, higher intensity services like the parent and infant units and the new community perinatal mental health and wellbeing teams will provide treatment, care and support to the three streams of people with the highest intensity support needs. These are the 'short-term treatment, care and support' stream, the 'ongoing treatment, care and support' stream and the 'ongoing intensive treatment, care and support' stream. People in the two earlier streams, 'communities and primary care' and 'primary care with extra supports', will receive their treatment, care and support from diverse supports and services. This includes support from family, carers and supporters and self-help resources, through to private psychologists and psychiatrists.

Figure 12.2: An overview of the future mental health and wellbeing system—perinatal



As shown in Figure 12.2, at the initial two levels, treatment, care and support is provided in people's homes or their local communities. This recognises the important role of family, carers and supporters, virtual communities and communities of place, identity and interest. Government and community services, such as organised and informal playgroups and parents' networks, are also important in supporting people at these levels.

Primary and secondary mental health and related services are often the first places in which professional help is provided. GPs, private psychologists and psychiatrists have a significant role in perinatal mental health and wellbeing, including those who have specialist training in perinatal mental illness.

Recognising that most prospective and new parents will receive treatment, care and support from primary and secondary care and related services, in the future mental health and wellbeing system, specialised perinatal mental health clinicians and support workers will 'reach in' to these levels and work directly with these clinicians and staff to build their capability to help more people. With more widely available 'specialist backup' provided to primary and secondary care and related services, more prospective and new parents will be able to get their treatment, care and support close to where they live.

As described in Chapter 10: *Adult bed-based services and alternatives*, the Commission intends that people admitted to hospital for physical health reasons will have increased access to integrated mental health treatment, care and support during their hospital stay through reforms to in-hospital mental health consultation liaison services.

This means that public maternity hospitals will be able to provide in-house mental health consultation liaison services like the Royal Women's Hospital currently does.[50] Further, the reformed funding for existing mental health consultation liaison services, like those at the Royal Women's Hospital, will better allow them to meet demand for supports in their services. This means, for example, that women with a pre-existing mental illness who give birth at a public hospital should have their physical and mental health needs supported by that hospital.

The remaining three levels comprise services that deliver more specialised, multidisciplinary mental health and wellbeing responses. Adult and Older Adult Local Mental Health and Wellbeing Services will offer treatment, care and support for perinatal mental illness. Reformed and expanded community perinatal mental health and wellbeing teams, located in Adult and Older Adult Area Mental Health and Wellbeing Services, will deliver specialised perinatal treatment, care and support in the community. At the highest intensity level are Victoria's six parent and infant units, which will provide treatment, care and support in a hospital environment to a small number of parents who need this level of support.

12.3.1 Reforming screening in primary and secondary mental health and related services

As noted earlier, a major feature of perinatal mental health services is the treatment, care and support provided by primary and secondary mental health and related services (for example, maternity services).

A common feature of perinatal mental health services around the world is screening for mental illness. Although screening is undertaken in many different settings, in Victoria it mainly occurs through maternity services, maternal and child health nurses and GPs. One of the reasons screening is so important is that mental illness can often arise for the first time during the perinatal period.[51] When undertaken correctly, screening for perinatal mental illness can support prospective and new parents who are at risk of, or are experiencing, perinatal mental illness to be identified and receive appropriate treatment, care and support.[52]

In Victoria's health system, there are two points at which perinatal mental health screening is mandatory. The first is as part of routine antenatal care at public health services that provide maternity and newborn care in Victoria.[53] The second is undertaken for postnatal depression by Victoria's maternal and child health nurses.[54]

The Commonwealth has also funded initiatives to increase rates of screening. Most recently, as part of a $43.9 million investment in the 2018–19 Budget, the Commonwealth funded the Centre of Perinatal Excellence (COPE) to roll out its digital mental health screening tool, referred to as iCOPE, in every public maternity hospital in Australia.[55] This includes funding to state and territory governments to encourage the uptake of iCOPE, along with or in addition to expanding services for perinatal support in the community.[56] In 2017 the Commonwealth also made changes to Medicare Benefits Schedule Item 16407 for a postnatal appointment between four and eight weeks after birth so that it now includes a compulsory mental health assessment.[57]

To be effective in helping people with perinatal mental health and wellbeing challenges, screening needs to be connected to referral pathways so when a person is identified as in distress or with a perinatal mental illness, there is a pathway to higher intensity care. Professor Harriet Hiscock, Paediatrician at the Centre for Community Child Health and Director, Health Services Research Unit at the Royal Children's Hospital , giving evidence in a personal capacity, emphasised the importance of accessible treatment, care and support subsequent to screening:

> **you have to have the resources available to be able to meet the needs of whatever you find. So, the worst you can do is turn up a number of issues and problems and not be able to address them and say, "Sorry, we've identified that, but we can't meet your needs for another 12 months because our waiting list is 12 months."[58]**

The Commission heard that too often when screening discussions indicate high-intensity mental health and wellbeing support needs, either those needs cannot be met or there is a long delay in accessing services. Maternal and child health nurses described having to refer to GPs or trying to support the mother until a place at a parent and infant unit became available.

Dr Michael Block, a consultant psychiatrist specialising in mother–infant psychiatry, commented:

> Whilst Maternal & Child Health Nurses now offer routine post-natal mood screening, there are no established pathways to care beyond the screening, many women will get no care beyond a suggestion that they see their GP.[59]

At a dedicated consumer focus group on perinatal mental health and wellbeing, the Commission heard about a wide range of experiences with screening for perinatal mental illness. For some, it was a positive experience that led to treatment, care and support. However, others indicated that clinicians are not always confident in using the screening tools, discussions could be rushed and responses inadequate.[60] One consumer indicated that:

> I was screened by a GP who was probably scared of me having postnatal depression and wasn't comfortable enough to refer me on to anyone else. I remember being in her office in floods of tears and saying, 'This child will not sleep.' .... I had no capacity to do anything else .... And she just kept cheerfully saying to me that children cry, don't worry about it. Now that's all well and good for her in that five-minute slot.[61]

For some people, screening can also be a challenging experience. Some consumers told the Commission they were uncomfortable participating meaningfully in screening out of fear of being stigmatised. Others feared that screening may lead to a connection with child protection services. This concern is also reflected in research that suggests women may be reluctant or fearful to truthfully disclose their thoughts because of perceived risks to their autonomy and their child or children.[62] The Commission heard directly from a new mother who said:

> I feel like admitting that you're not doing well would put your baby in jeopardy and you have that fear of your baby being taken off you ... I don't even think I was completely honest with how I was feeling. I probably sugar coated it because deep down I was probably scared that my baby was going to get taken off me. And that they would, they'd be like, okay, the baby's in danger because she's feeling like this ... we need to be allowed to be honest and know that worst case scenario is not going to happen. They're going to help us.[63]

Experiences of screening can also differ depending on personal and cultural context. For example, research suggests that fear, trust and stigma all play a part in some Aboriginal women's discomfort with openly discussing their experiences during screening.[64] Some women may not act on post-screening referrals because they do not think those services are culturally safe for them.[65] Commonly used screening instruments also have known limitations, including in their validity and acceptability among men, Aboriginal communities and culturally diverse populations.[66]

In the future system, perinatal mental health screening will be enhanced through a review of screening practices in Victoria and better connections to treatment, care and support following screening.

A review of screening practices to address inclusivity, cultural appropriateness and the therapeutic context of screening

In response to the concerns outlined above and recognising the importance of screening being meaningfully and clinically valid for diverse populations, the way screening is delivered in Victoria will be reviewed. This review will be commissioned by the Department of Health and will involve clinicians, academics and people with a lived experience of perinatal mental illness. The review will consider:

- strategies to improve the effectiveness and take-up of screening, including approaches that consider fear of disclosure, cultural suitability and that include non-birth parents in screening
- strategies for supporting clinicians and support workers in public hospitals and maternal and child health nurses to conduct screening effectively—this includes ensuring screening occurs in the context of a therapeutic discussion, is administered using sensitive enquiry techniques and people are connected with treatment, care and support, as appropriate
- alignment with the Commonwealth *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline (October 2017).* This national guideline states that the postnatal screening should be completed twice in the first year: initially six to 12 weeks after birth, followed by a repeat screening at least once in the first postnatal year.[67] In comparison, the current Victorian *Maternal and Child Health Service Practice Guidelines 2009* indicate that postnatal screening should be completed at least once, at the four-week maternal and child health 'key age and stage consultation' (or no later than eight weeks).[68]

In undertaking this review and implementing the recommendations, the Department of Health will work with the Commonwealth Government in the context of the recommendations on perinatal mental health in the Productivity Commission's *Mental Health Inquiry Report*. The report indicated that 'governments should take coordinated action to achieve universal screening for mental illness for all new parents',[69] and that this should include 'fathers and partners in any policies to support perinatal mental health screening'.[70]

Connections to treatment, care and support

For screening to have a positive impact on mental health and wellbeing outcomes, it must be built into a system of treatment, care and support.[71] Clinicians undertaking the screening will need to understand the continuum of treatment, care and support that is available to prospective and new parents in their area.

Post-screening, some people may be connected to local supports, such as peer-led support groups (support programs run by people with lived experience of perinatal mental illness). For others, online resources and apps, including those that connect people to psychological therapy, may be useful. For others, a referral to a GP to consider seeking subsidised psychology via a mental health plan may be the most appropriate path. Depending on their preference, people may choose a combination of ways to receive help.

The screening process may identify a person who is experiencing perinatal mental illness that requires higher intensity mental health treatment, care and support. People needing this level of support will be referred to the reformed and expanded community perinatal mental health and wellbeing teams by a medical practitioner.

As well as referring to community-based supports provided by government, non-government and peer-led organisations, the new community perinatal mental health and wellbeing teams (outlined below) will establish clear referral pathways with primary, secondary and related services. This will ensure primary, secondary and related services have an appropriately higher intensity service to refer people to if needed, based on the result of their perinatal mental health screen. Community perinatal mental health and wellbeing teams will ensure strong connections and referral pathways exist across multiple services used by prospective and new parents, including:

- services that undertake perinatal screening, such as maternity hospitals, GPs and maternal and child health nurses
- services where people go for help with challenges in transitioning to parenthood, such as early parenting centres
- parent and infant units.

12.3.2 Community-based care in Adult and Older Adult Area Mental Health and Wellbeing Services

As a major feature of the future treatment, care and support for perinatal mental health and wellbeing, each Adult and Older Adult Area Mental Health and Wellbeing Service will be funded to establish community perinatal mental health and wellbeing teams.

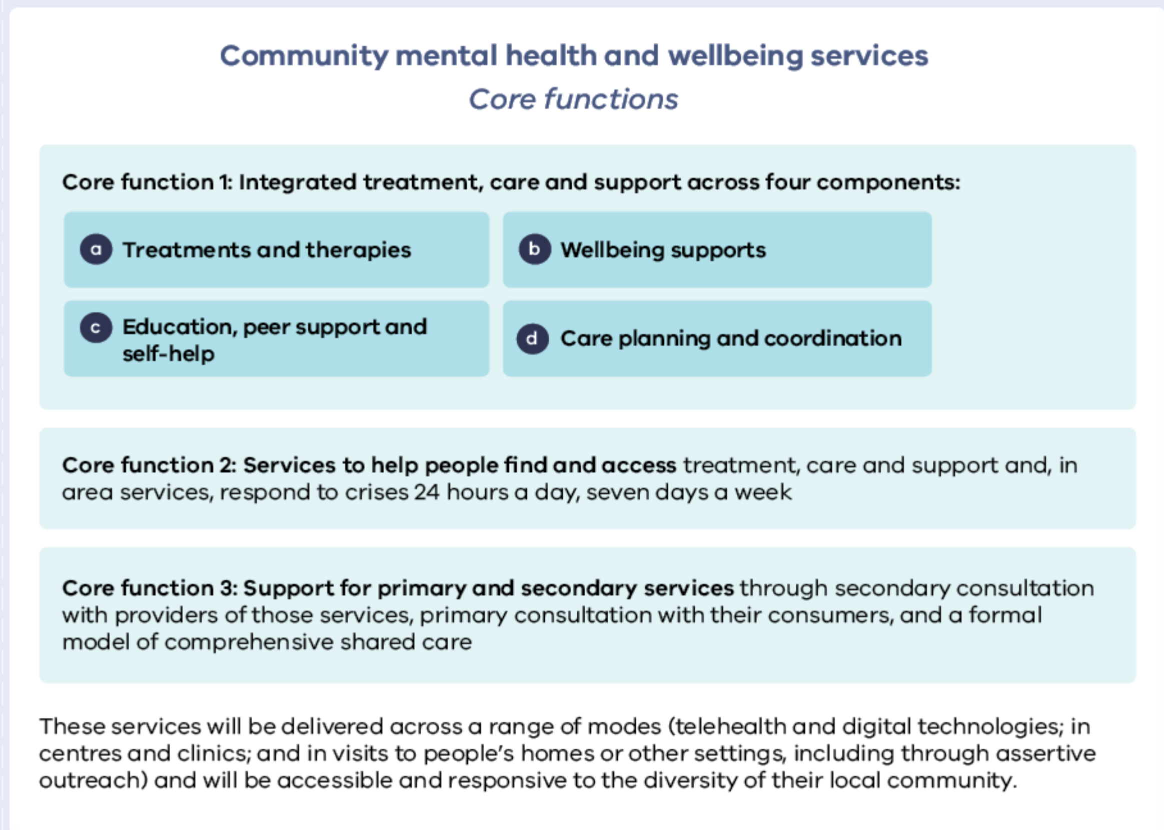
These teams will draw on the existing resources in the Perinatal Emotional Health Program, with this program renamed and reformed into community perinatal mental health and wellbeing teams. These teams will provide treatment, care and support to the three streams of people with the highest intensity support needs: the 'short-term treatment, care and support' stream, the 'ongoing treatment, care and support' stream and the 'ongoing intensive treatment, care and support' stream.

The community perinatal mental health and wellbeing teams will be multidisciplinary and staffed by clinicians and support workers specialising in perinatal mental health and wellbeing. Lived experience workers (people who have a lived experience of perinatal mental illness) will be part of the multidisciplinary teams. Consideration should be given to how best to maximise their experiences and insights, including coordinating non-clinical supports and providing emotional support and help to navigate the system.

The teams will be based in the community so they can focus on people experiencing perinatal mental health and wellbeing challenges as early as possible.

The new perinatal community mental health and wellbeing teams will deliver the Commission's community mental health and wellbeing services' core functions, tailored to perinatal mental health and wellbeing. The core functions are summarised in Figure 12.3 and are described in detail in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults.*

Figure 12.3: Community mental health and wellbeing services—core functions



Under Core function 1.a: Treatments and therapies, the new teams will provide assessment and evidence-based antenatal and postnatal treatment and therapies. A broad range of therapies will be offered, including psychological therapies, pharmacological therapies, trauma-informed therapies, speech therapy, occupational therapy and arts and creative therapies.

The teams will have an important role in providing antenatal and postnatal treatment, care and support for parents living with an existing mental illness, including working with other adult mental health clinicians and support workers and the prospective or new parents on safe medication management.

The teams will also support families, carers and supporters to better understand perinatal mental illness and how to best support the person they are caring for. This could include connecting them to locally based supports, such as PANDA's National Helpline, online communities and self-help material.

Under Core function 1.b: Wellbeing supports, the teams will deliver wellbeing supports that are integrated with the clinical supports a person is receiving. This means the needs of prospective or new parents will be considered holistically. While the wellbeing supports will be tailored for each person, they could, for example, include practical support to help with the transition to independent parenting.

Core function 1.c: Education, peer support and self-help, and 1.d: Care planning and coordination, will be delivered consistently with the rest of the adult and older adult mental health and wellbeing services as described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults.*

Core function 2 provides for services to help people find and access treatment, care and support and, in area services, respond to crises 24 hours a day, seven days a week. Under this core function, a referral from a medical practitioner such as a GP, paediatrician or psychiatrist will be required to access the perinatal community mental health and wellbeing teams. This will preserve the highly specialised perinatal community mental health teams for people with the most complex support needs.

Community perinatal mental health and wellbeing teams will be able to conduct 'initial support discussions' and 'comprehensive needs assessment and planning discussions' as outlined in Chapter 8: *Finding and accessing treatment, care and support*. Those discussions will allow a thorough assessment and consideration of needs with clinicians and support workers trained in perinatal mental health. Depending on the outcomes of these discussions, the perinatal mental health clinician or support worker will work with the prospective or new parent to better understand their needs. They will then work together to jointly agree on funded treatment, care and support that reflects the prospective or new parent's preferences, strengths, goals and individual and family situation.

Under Core function 3: Support for primary and secondary services, clinicians and support workers from the perinatal community mental health and wellbeing teams will 'reach in' to provide 'specialist backup' to support primary and secondary care and related services (such as maternity services) to help more people with perinatal mental illness. This support will primarily be for maternal and child health nurses, GPs and maternity services. It will be in the form of primary and secondary consultation, where clinicians and support workers from the community perinatal mental health and wellbeing teams provide specialist capability building, limited joint clinical care and formalised shared-care arrangements.

As with all Adult and Older Adult Mental Health and Wellbeing Services, these new teams will increase the range of ways that people can access help, with the default of clinic-based appointments to be complemented by group programs, targeted home visiting as needed and highly targeted assertive outreach.

As well as complementing individual sessions, group programs allow people to benefit from peer learning (where group participants learn from one another) and to understand the different perspectives from people who are facing similar challenges. Where necessary, safe and acceptable to prospective or new parents, home visiting can minimise disruptions to routines, which are important to an infant's development, and allows clinicians and support workers to better understand home environments. Highly targeted assertive outreach can be beneficial for consumers with perinatal mental illness who find clinic-based appointments challenging and prefer alternative ways of engaging.

While perinatal mental health services have historically been delivered by adult area mental health services, increasingly, these services are moving to a model where perinatal and infant mental health services are integrated into child and adolescent mental health services and child and youth mental health services. This recognises the relationship between the mental health of the parents and the emotional development of the infant. It will be important that in each Adult and Older Adult Area Mental Health and Wellbeing Service, structures that integrate care for parents and infants are established. This could be achieved by:

- recruiting infant mental health clinicians and support workers into community perinatal mental health and wellbeing teams
- promoting shared care through two-way referrals (with the consent of the consumer), case conferencing and sharing staff and joint clinical work with the infant mental health teams in the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services
- delivering perinatal and infant mental health services from the same service.

12.3.3 Statewide services—parent and infant units connected to community-based care

The new community perinatal mental health and wellbeing teams will become the main referral point into parent and infant units and provide community-based care to parents who are waiting to be admitted. This will ensure parents and babies are supported by specialist perinatal mental health clinicians and support staff while they wait for a place to become available.

Obtaining care in the community after an admission to a parent and infant unit can be difficult. One mother told the Commission:

> When I left the mother and baby unit after having my son, I was told to self-refer to a psychiatrist who charged $500 for the initial session.[72]

The community perinatal mental health and wellbeing teams will address this by supporting parents discharged from parent and infant units with treatment, care and support in the community. This will support parents in the transition back to their home and community.

The Commission heard conflicting advice regarding the need to increase the capacity of Victoria's six parent and infant units. Clinicians who refer parents to parent and infant units indicated that access was difficult and that a lengthy wait is a common experience. For example, Ms O'Brien stated that:

> We refer people off to mother baby units, but they're so hard to get into. And then you know, the really difficult part about our role here is when we know that they need to go to a mother baby unit, and there's no beds available, so you send them home with their partner on you know, almost 24 hour watch, because we can't get the service system to respond in a timely manner.[73]

Parents and family members also spoke of limited access and the impacts of waiting periods on parents, infants and their families. For example, one person spoke of a family member who suffered a postnatal mental illness requiring hospitalisation:

> She was separated from her breast-fed 14 week old baby for 3 weeks due to the lack of mother-baby unit facilities. That placed significant added stress on the mother [and] the family trying to work around this issue.[74]

However, this conflicted with advice from four of the health services that operate the parent and infant units, who reported wait periods ranging from just over a week, to less than a week or no waiting period at all.[75]

On balance, including considering Commission modelling of supply and demand, the Commission does not consider it a high priority to increase the capacity of the parent and infant units. The new community perinatal mental health and wellbeing teams will greatly increase the availability of treatment, care and support, and this increased availability, along with care being provided earlier in illness, makes it likely that fewer parents will need an inpatient admission.

The Commission acknowledges that access to Victoria's six parent and infant units is not always equitable, particularly for regional and rural areas. Women from these areas that need this level of treatment, care and support can have to travel considerable distances and this can make it difficult for other parents, siblings and family members to visit and participate, for example, in family therapy.[76] In future service planning for parent and infant units, the Department of Health should consider ways to increase equity of access to these services.

There are also opportunities to increase the effectiveness and efficiency of the existing parent and infant units, which the Department of Health should consider. These include:

- reviewing the model of care at the parent and infant unit in Ballarat, which currently only cares for parents with 'mild to moderate' perinatal mental illness[77]
- considering standardising admission criteria across Victoria and identifying opportunities at each unit to ensure appropriate levels of bed utilisation
- ensuring all units can admit mothers on weekends, as well as on weekdays, which will increase the number of mothers who can access the units
- ensuring infant mental health clinicians and support workers form part of the multidisciplinary teams in parent and infant units so that there is a balanced focus on the parent's needs, the infant's needs and on strengthening the parent–child relationship.

12.4 The future infant, child and family mental health and wellbeing service stream

This section of the chapter outlines reforms to better support the mental health and wellbeing of infants and children aged 0–11 years, and their families.

Many families, carers and supporters who had sought help for their infant's or child's mental health and wellbeing challenges told the Commission of the urgent need for reform. This was echoed by many infant and child mental health clinicians, academics and service providers. For example, Ms Alison Smith, Divisional Manager for Child and Youth Mental Health at Austin Health, emphasised the opportunity the Commission has to achieve significant change:

> If we invest early, we change people's trajectories. We end up with a healthier system and a healthier group of families down the track. And that investment is repaid over and over and over. So I'd be very, very keen to be brave in Victoria and do something different.[78]

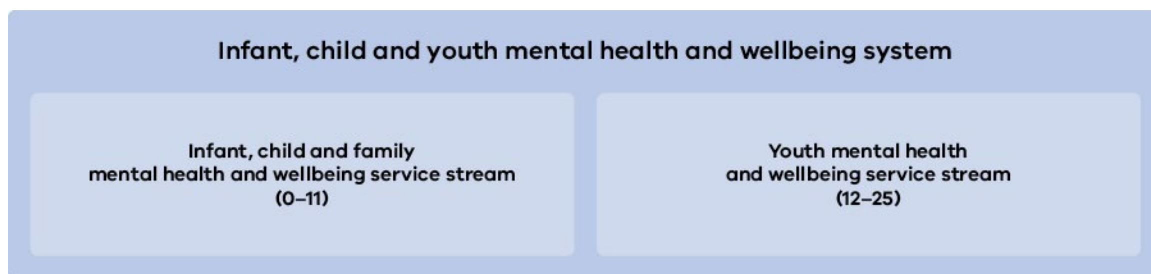
Giving evidence in a personal capacity, Professor Frank Oberklaid AM OAM, a paediatrician at the Royal Children's Hospital and Co-Group Leader of Child Health Policy, Equity and Translation at the Murdoch Children's Research Institute, provided similar encouragement to the Commission to aim for major change:

> A fundamental rethink of our approach to child mental health is required as there are macro, structural and systemic issues which need to be addressed for any reform of Victoria's mental health system to be successful. [79]

The Commission has responded by designing a service stream of treatment, care and support specifically for infants and children (spanning 0–11, inclusive of the 11th year) and their families. This adopts the framework of a responsive and integrated system of treatment, care and support used in all other age-based service streams. It also mirrors the same underlying features such as treatment, care and support that is compassionate, recovery-oriented and proportionate to needs and people's strengths and is anchored in care predominately delivered in the community. However, it also has its own underlying approach, model of care and culture, tailored to the context and experiences of infants and children.

The future infant, child and family mental health and wellbeing service stream exists within the broader infant, child and youth mental health and wellbeing system, as shown in Figure 12.4.

Figure 12.4: Infant, child and youth mental health and wellbeing system



Within this broad system, there are two service streams—one for infants, children and families (aged 0–11 years) and another for young people (aged 12–25 years). The decision to create two service streams within the one system was informed by advice from clinicians, service providers and academics about the noticeable differences between infants, children and young people in developmental stages, mental health and wellbeing challenges and effective models of care. The Commission considers that the needs of infants and children, and of young people, will be best served through two service streams that are sensitive to, and better reflect, these differences.

Infant, Child and Family Area Mental Health and Wellbeing Services will be a dedicated service stream within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services set out in recommendation 3. While the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services are for infants and children aged 0–11 years, there are developmental differences within this age range. To ensure treatment, care and support are developmentally appropriate and there is a degree of specialisation, services are expected to tailor their models of care to the age cohorts of 0–4-year-olds (encompassing infants, toddlers and preschoolers) and 5–11-year-olds (encompassing the breadth of the primary school years).

Some children may need treatment, care and support in both the 0–11 and 12–25 service streams as they grow and develop. In each area there will be one Infant, Child and Youth Area Mental Health and Wellbeing Service. That will mean common providers and shared clinical governance across the age range of 0–25 years. This will provide a safety net against disruptions in treatment, care and support for children who need to transition to the youth service stream. Within each region, the service providers will be held accountable for smooth transitions and continuity of care. This should also assist families with several children of different ages who need treatment, care and support.

In establishing the two service streams within each Infant, Child and Youth Area Mental Health and Wellbeing Service, the Commission expects there will be flexibility for local decision making about the right age for a child to transition between the two service streams based on their needs and preferences. In particular, consideration should be given to differences between a child's developmental and biological ages, and to which service stream can best meet the child's needs at different points in time.

The future infant, child and family mental health and wellbeing service stream will recognise the importance of families, carers and supporters and it will respect the caring role as fundamental for the infant or child. The Royal Australian and New Zealand College of Psychiatrists emphasised how central families, carers and supporters are in supporting their infant or child to deal with mental health and wellbeing challenges:

> Much child and adolescent mental health practice aims to bring change in family dynamics and parenting as much as to the individual child themselves. Much practice aims to assist or influence parents' knowledge, understanding, interactional behaviours and emotional or relational stance towards the child to bring positive change. This needs to involve relational and emotional engagement with parents.[80]

The reforms the Commission has recommended will strengthen the focus on families. These reforms will provide treatment, care and support sensitive to the family's dynamics, situation and strengths. They will also focus on strengthening the infants or child's relationships with their family, carers and supporters.

To ensure families, carers and supporters are embedded in the framing and conception of this service stream, alongside infants and children, the Commission has renamed this service stream as Infant, Child and Family Area Mental Health and Wellbeing Services.

The new infant, child and family mental health and wellbeing service stream has been developed by the Commission at approximately the same time as development of the *National Children's Mental Health and Wellbeing Strategy*—a process led by the National Mental Health Commission.[81] While at the time of writing only the draft *National Children's Mental Health and Wellbeing Strategy* was available to the Commission, it is evident that there is a great deal of alignment and shared momentum.

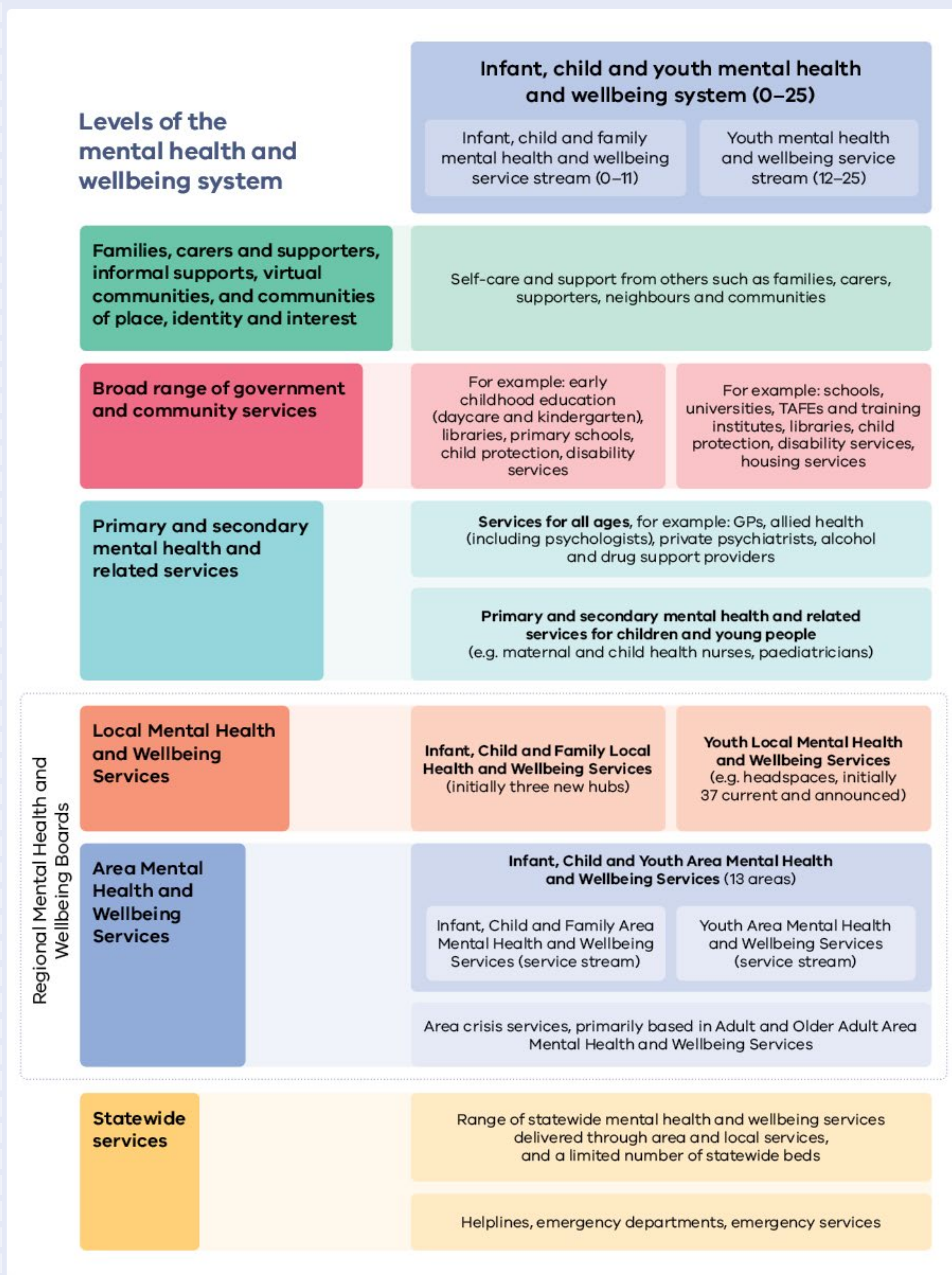
The draft *National Children's Mental Health and Wellbeing Strategy* proposes a range of initiatives that Victorian families would benefit from including a national campaign promoting the value of parenting programs and amending Medicare items to promote collaborative care including case conferencing.[82] The implementation of this new national strategy provides opportunities for the Department of Health to work collaboratively with the Commonwealth Government to maximise the impact of the planned reforms for Victorians.

12.4.1 Architecture for the future service stream

As described in Chapter 5: *A responsive and integrated system*, across all age groups, the Commission has established a community-based system of networked Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services that work together to provide a wide range of integrated treatment, care and support for all Victorians who need help with their mental health and wellbeing.

The application of that overall architecture to the infant, child and family mental health and wellbeing service stream is set out in Figure 12.5, alongside the youth mental health and wellbeing service stream.

Figure 12.5: An overview of the future mental health and wellbeing system—infant, child and youth



Note: Developmentally appropriate transitions will be applied between age-based systems and service streams.

At the initial level are responses to promote good mental health and wellbeing for all infants, children and families. These responses include playgroups, sporting clubs, websites like the Raising Children Network, self-help apps and a wide range of online communities. At the following level, services outside the mental health system support infants and children to develop, learn and explore their world. These include early childhood settings such as kindergartens and primary schools, some of which have their own mental health clinicians and support staff.

The next level comprises primary and secondary mental health and related services. For infants and children, these services include maternal and child health nurses, GPs, paediatricians, psychologists and other allied health professionals who provide young people with mental health treatment, care and support.

The remaining three levels include services that deliver a specialised, multidisciplinary mental health response to smaller and smaller numbers of infants and children at each level. These are for children and families who require higher intensity services. For infants and children, Local Mental Health and Wellbeing Services of the type outlined in this report generally do not exist in Victoria. Instead, in the future system, the Victorian Government will work with the Commonwealth Government to introduce Infant, Child and Family Health and Wellbeing Hubs to fulfil the role of Local Mental Health and Wellbeing Services for 0–11-year-olds.

There will be three of these **Infant, Child and Family Local Health and Wellbeing Services** in the form of Infant, Child and Family Health and Wellbeing Hubs initially, and they will be networked with the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services.

Currently, area mental health services for children and young people are called child and adolescent mental health services for people 0–18 years, or child and youth mental health services for children and young people 0–25 years. Both types of services will become services for 0–25-year-olds and will be named '**Infant, Child and Youth Area Mental Health and Wellbeing Services**'. Within those services a service stream for 0–11-year-olds will be named **'Infant, Child and Family Area Mental Health and Wellbeing Services'**. A separate service stream will cater for young people.

The 13 Infant, Child and Youth Area Mental Health and Wellbeing Services will be delivered through partnerships between a public health service or public hospital and a non-government organisation that provides wellbeing supports.

The 13 Infant Child and Youth Area Mental Health and Wellbeing Services are the entities that will be commissioned to deliver services. The Commission recognises the language for the new infant, child and youth mental health and wellbeing system is technical, but for governance purposes has deliberately distinguished that the *service streams* are *part* of the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services, to be clear that they are not in and of themselves separate entities.

While the system will be anchored in services that are delivered in the community, it will be complemented by treatment, care and support in statewide hospital and bed-based residential services, for the rare occasions when infants and children need help best provided in a bed-based setting. To complement the existing acute inpatient beds for infants and children aged 0–11 years with the most intensive treatment, care and support needs, new subacute residential centres that support family admissions will be established.

Personal story:

Nicola

Nicola* and her eight-year-old son Henry* live in regional Victoria. When Nicola became concerned that Henry's mental health was deteriorating, she spoke to her maternal child health nurse, who referred her to her GP.

Henry has now been diagnosed with attention deficit hyperactivity disorder, and he experiences anxiety and oppositional defiant disorder behaviour.

Nicola found it very difficult to access support in a small regional town. Limited public services meant she has incurred significant out-of-pocket expenses, including gap payments, to see private psychologists and paediatricians, often travelling long distances to regional centres to access them.

She noted that while she wants to support Henry as much as she can, she doesn't always have the money to spend on services for him.

Henry's private psychologist suggested Nicola seek support from the local child and youth mental health service when his behaviour started escalating.

> I had to fight really hard to get him into the local child and youth mental health services, and for whatever reason, he struggled to engage with the worker, and there was no one else. She did persevere for quite some time but then had to close our case as they weren't making any progress.

Nicola said the support Henry has received has been very fragmented due to circumstances such as clinicians moving away, retiring or having limited alternatives within the same service.

> He's been with six mental healthcare workers. It's really hard because the poor guy seems to make a bit of a connection with someone and then they move on.

The consequence of this on transitioning between services is also difficult for Nicola.

> I keep records and basically every time we start with a new service, I whip out all these records again and re-tell the story. I've told the story so many times, it is really frustrating.

Nicola is concerned that Henry is approaching his teenage years with little support. She has been told about specialist services in Melbourne, and even Sydney, but the travel and cost are prohibitive.

> My biggest concern is probably the future. We get loads of ideas we can try, for example, behavioural therapies, but they're down in Melbourne. So depending on what type of appointment it is, that is driving three and a half hours and potentially accommodation.

Nicola feels more should be done to support access in regional communities. In her experience, Henry engages better with services face to face, so telehealth services are not always a viable option.

> If you get him drawing or you play to his interest like Lego, he can be quite chatty. So that's where phone and zoom meetings are not the same, they're not going to have that effect on him. Face to face he knows that Mum is just outside, but whatever he wants to talk about is private.
>
> I'd love to see more accessibility. Something to entice specialists to work in the area, even if they come to the town a few days per week. I'm sure there are probably so many families who can't fork out any money at all, or who can't travel for whatever reason, and I'm sure there are many children around the area that are missing out. It shouldn't matter what your postcode is, you should be able to access these basic services.

Nicola said she has received little support herself and has focused on accessing support for Henry. Although she's often felt that she would just deal with things by herself, Nicola would like to see an automatic referral system where when a referral is made for a child, support for parents is included to focus on how the parents are coping.

> I know a lot of children's mental health services often work with families, with for example, parenting programs, but focus on how they're coping. I do feel really judged being in a small town, so I think having that support as well would be a great idea.

Source: RCVMHS, *Interview with 'Nicola'* (pseudonym), September 2020.

Note: * Names have been changed to protect privacy.

12.4.2 The core concepts that underpin the future service stream

The future infant, child and family mental health and wellbeing service stream has been designed around the following four core concepts, which are further outlined below:

- a balanced approach to emotional wellbeing, behavioural and developmental challenges and mental health
- developmentally and relationally informed treatment, care and support
- a focus on early intervention
- recognising the many systems that support infant and child mental health and wellbeing.

A balanced approach to emotional wellbeing, behavioural and developmental challenges and mental health

The future service stream for infants and children will move away from determining eligibility for services based on diagnosable mental illness. It will use a much broader approach to eligibility—one that considers emotional wellbeing, behavioural and developmental challenges and mental health. This approach is more appropriate in these early formative years when development occurs so rapidly.

Research supports this approach, suggesting that mental illness in infants and children is much more grey than black or white, often presenting as developmental and behavioural concerns that may not suggest a clear diagnosis of mental illness.[83] While infants and children can develop many of the same mental health and wellbeing challenges as adults, they often present in different ways, making them harder to identify and diagnose as mental illness.[84] Common mental health challenges at key transition points are summarised in Table 12.1 and show how infants and children might present differently depending on their stage of life.[85]

Table 12.1: Various ways mental health challenges in children may manifest across ages

Infants (0–3 years)	Preschool (3–5 years)	Primary school (6–11)
Mental health challenges or distress can be experienced as persistent sleep, feeding and crying problems (lasting more than three months and not explained by medical causes and sometimes referred to as settling difficulties), failure to thrive, developmental delays, avoidance of eye contact and failure to seek interactions with others. Infants can be anxious and tense, distressed or fearful.	Mental health challenges or distress can be experienced as persistent aggression, separation anxiety, sleep issues, developmental delays, tantrums and dysregulated behaviour, language delay, an inability to regulate emotions, anxiety and sadness. Children can sometimes be withdrawn, hypervigilant and clingy and not actively participating. They can also be excessively shy in social interactions.	Primary school–aged children experience similar issues as 3–5 year-olds, as well as refusal to go to school, low self-esteem (especially in the context of co-occurring learning difficulties), hyperactivity and inattention, which causes disruption to peers and affects their ability to learn in the classroom. If they have anxiety-related issues, they can present with recurrent physical complaints such as stomach pain and headaches.

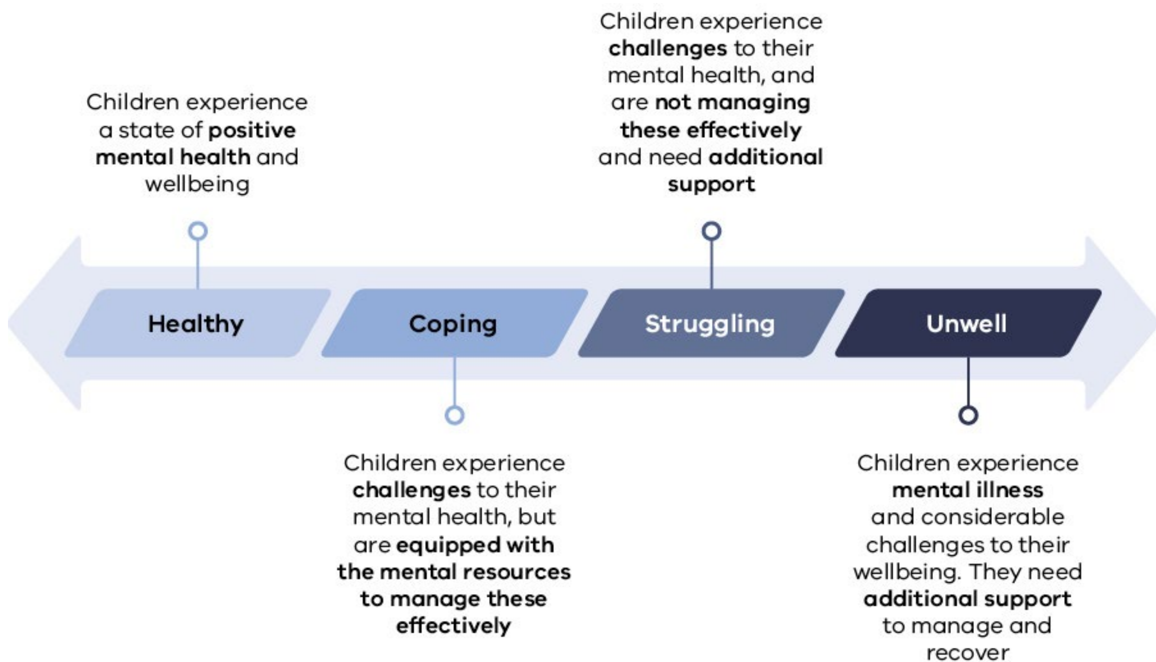
The Commission heard that attempts to diagnose mental illness in infants and children can be difficult and requires a different set of considerations than diagnoses in young people and adults do. Professor Newman submitted to the Commission that:

> Diagnosis of mental illness and defined disorders in infants and young children is a complex issue as disorders are in the process of developing and have less clearly defined boundaries ...[86]

For some families, carers and supporters, mental health and wellbeing challenges in infants and young children can be a confusing, confronting and sometimes stigmatising experience. A less prominent focus on diagnosable mental illnesses may encourage people to seek help and increase accessibility of services.

The Commission notes that the draft *National Children's Mental Health and Wellbeing Strategy* endorses a similar approach to child mental health and wellbeing, introducing the concept of the 'wellbeing continuum' as a 'fundamental cultural shift in the way we think about the mental health and wellbeing of children'.[87] As part of this shift, the strategy endorses a move away from terminology previously used of 'mental health' and 'mental illness', to that expressed in Figure 12.6.

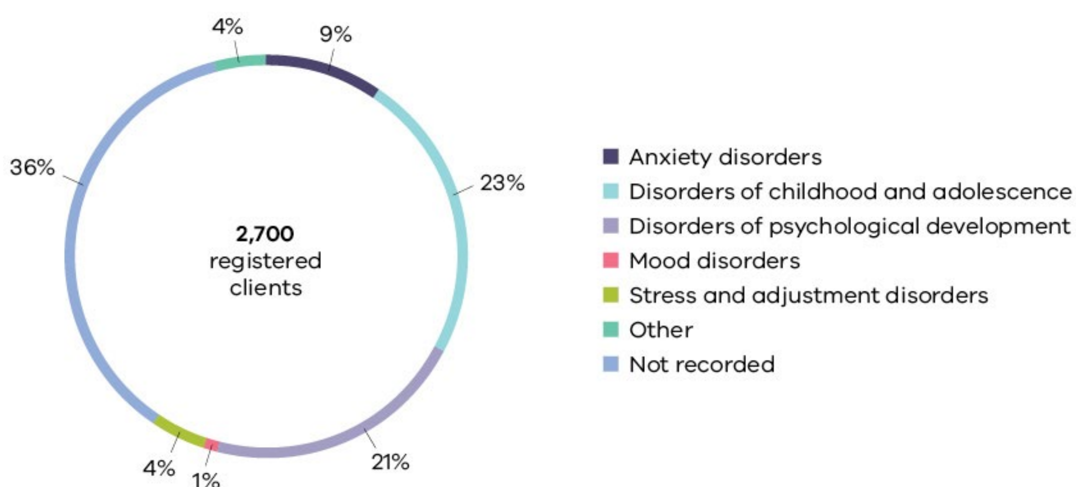
Figure 12.6: The draft National Children's Mental Health and Wellbeing Strategy's proposed wellbeing continuum



Source: National Mental Health Commission, *National child mental health and wellbeing strategy*, 2020, <www.mentalhealthcommission.gov.au/mental-health-reform/childrens-mental-health-and-wellbeing-strategy>, [accessed 17 December 2020].

Noting the challenges with an over-emphasis on diagnosis and mental illness described earlier, Figure 12.7 shows the principal diagnosis trends of infants and children receiving treatment, care and support from child and adolescent mental health services and child and youth mental health services in 2019–20. These are a different set of trends from those seen in the older age groups and demonstrate that clinicians and support workers need to be highly skilled in supporting a significant range of different presenting challenges and diagnoses.

Figure 12.7: People treated by the public specialist mental health system aged 0–11 years, by principal diagnosis groups, Victoria, 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

Notes: *The International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification* (ICD-10-AM) classifies diagnoses as follows: anxiety disorders include generalised anxiety disorders, social phobias, specific phobias and panic disorders; disorders of childhood and adolescence include attention deficit hyperactivity disorder and conduct disorder; disorders of psychological development include developmental language disorder, learning disorders and autism spectrum disorders; mood disorders includes depressive and bipolar disorders; stress and adjustment disorders include acute and/or severe stress, post-traumatic stress or adjustment disorders; other include disorders not classified elsewhere; and not recorded includes cases where a diagnosis was not recorded due to collection error or the case did not warrant a diagnosis.

For the purposes of this figure, other includes eating disorders, obsessive compulsive disorders; organic disorders; personality disorders; schizophrenia, paranoia and acute psychotic disorders; substance abuse disorders and disorders not classified elsewhere.

This analysis does not include 'unregistered clients'. Services delivered to unregistered clients is even higher for children and youth mental health services where 17 per cent of contacts were delivered to consumers that were not registered.

Data excludes the Albury campus of Albury Wodonga Health.

See Volume 5, Appendix B for additional information.

Developmentally and relationally informed treatment, care and support

The new infant, child and family mental health and wellbeing service stream will emphasise treatment, care and support delivered in the context of an infant's or child's developmental stage and their relationships.

To provide developmentally informed treatment, care and support, clinicians and support workers must have a good understanding of the typical developmental stages of infants and children, including cognitive, emotional and behavioural aged-based milestones, as well as normal developmental variations across genders. Developmentally informed treatment, care and support also applies to engagement strategies, treatments and therapies. For example, with infants, it recognises that therapy is mostly delivered through the parents, carers and supporters and that play-based therapy is often used for preschoolers and primary school–aged children.

To provide relationally informed treatment, care and support, clinicians and support workers spend time understanding the relationships that are important in the infant or child's social context and how experiences through relationships may hinder development or support the infant or child to thrive.[88] Relationally informed treatment, care and support focuses on three levels: on the individual infant or child; on parents, carers or supporters; and on the family unit. This approach recognises that the infant's or child's family (whatever it looks like) forms the environment in which they develop. Relationally informed treatment, care and support draws on the family's collective strengths and fosters positive relationships between family members. In the Productivity Commission's *Mental Health Inquiry Report*, the Australian Association of Infant Mental Health describes the importance of relationally informed treatment, care and support:

> The main thrust of infant mental health work is around relational work. It's around the attachment between the little one and his or her primary carers as a vehicle for treatment. So in other words, [our] preference and its main modality for working is actually in a relational way, rather than ... pharmacology or even behaviourally oriented interventions.[89]

Professor Newman also emphasised this:

> The focus of support and intervention includes both the parents/carers and the infant/child and is based on a model that recognises the significance of attachment relationships and context. This requires comprehensive assessment of the child in the context of their family and caretaking relationships and their overall development.[90]

Relationally informed treatment, care and support also recognises the social determinants of health as factors that influence an infant's or child's mental health and wellbeing. Giving evidence in a personal capacity, Professor David Coghill, Financial Markets Foundation Chair of Developmental Mental Health at the Royal Children's Hospital, discussed the importance of the social determinants:

> [There are] many social determinants of health that really impact not just on the prevalence but on the severity and the impact of mental health disorders in infants and children, and in no particular order I would list these as poverty, living away from home, ... children who are received into care, being Aboriginal or a Torres Strait Islander, all other forms of marginalisation, whether it ... be by culture, ethnicity, colour, sexuality and/or language; those who are or have suffered from abuse, neglect or other significant traumas, those with refugee backgrounds.[91]

Some of these factors, such as the child's socioeconomic status, are structural in nature and harder to modify, especially in the short term, while other factors such as stable housing and supportive relationships are more amenable to intervention.[92]

While understanding the presenting symptoms and behaviours of infants and children who need help remains important, they will now be seen and understood in the context of the infant's or child's developmental stage, relationships and social determinants.

A focus on early intervention

Evidence indicates that treatment, care and support for mental illness or psychological distress early in life can effectively improve health and wellbeing into the future. Research suggests that early therapeutic intervention can be highly effective at limiting the severity and progression of challenges[93] and that first symptoms typically occur several years before a mental, emotional or behavioural disorder.[94] Professor Newman agrees that early intervention is crucial:

> [The] better identification of infants and young children experiencing challenges to development … involves both identification of risk factors …. (often presenting as developmental delay and/or behavioural disturbances) and also better identification and support for vulnerable families or carers during the early parenting stage. This is particularly important in cases involving vulnerable parents who have experienced significant trauma themselves or are currently in high risk situations (for example, those experiencing domestic violence or social disadvantage).[95]

This identification can occur across the service stream, with multiple opportunities for early intervention during an infant's or child's life. The Australian Medical Association (Victoria) observed that:

> Early identification of mental illness and other disorders occurs when the young person is observed to be distressed and struggling to function at home, or in care or education settings. They might talk to an educator, support worker or consult a health care professional like a GP, paediatrician or a maternal and child health nurse. The child might then be referred by a parent or clinician for an early psychological assessment (through the Better Access program, a school psychologist or headspace), an urgent crisis assessment (emergency department) or CAMHS/CYMHS [child and adolescent mental health services and child and youth mental health services] for a comprehensive tertiary assessment.[96]

Recognising the many systems that support infant and child mental health and wellbeing

Multiple systems funded by the Victorian Government have a responsibility to support infant and child mental health and wellbeing. These systems deliver services and supports via a range of settings that generally correspond to the life stage of the infant or child and include maternal and child health nurses, schools and child protection.

Across several systems, there is a focus on providing support in the early years. Many social policy areas of government are investing in supporting children in these formative years, particularly in early childhood education through the *Education State Early Childhood Reform Plan*.[97] As noted by Ms Kim Little, Deputy Secretary of Early Childhood Education in the Victorian Department of Education and Training, 'what happens in early childhood matters for life. The foundations for a child's long-term development are laid in early childhood.'[98] For some infants and children, statutory child protection, Child FIRST/The Orange Door and family violence services will also be supporting their health and welfare.

During infancy and childhood, there are opportunities to identify a child's emotional, behavioural, developmental and mental health challenges. Dr Nick Kowalenko, Senior Clinical Adviser at Emerging Minds, emphasised the importance of these opportunities in the early identification of infants' and children's mental health and wellbeing challenges:

> Service providers that have the most contact with children are the ones most likely to identify difficulties and vulnerabilities. For example, behavioural difficulties may often manifest in the school setting … For infants, it is usually early childhood health nurses (in Victoria) where feeding or sleeping difficulties are identified. For pre-schoolers, it is the early childhood education and care services and GPs, as they are often a key source of advice. In the school sector, you have significant input from welfare teachers and school counsellors.[99]

As much as possible, treatment, care and support should be provided in these settings to take advantage of children's and families' familiarity and connections with them.

In particular, primary schools, with their universal reach, provide opportunities to identify children with mental health and wellbeing challenges, which can then be referred to treatment, care and support either available at the school or in a clinic-based setting. Giving evidence in a personal capacity, Associate Professor Alessandra Radovini, Director of Mindful at the University of Melbourne and Consultant Psychiatrist at Orygen, indicated that:

> School staff are in a position where they often can identify students at risk, or those experiencing mental health problems in the school environment, often presenting as behavioural or emotional dysregulation.[100]

Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect* outlines how primary and secondary schools will be supported in the future. This includes funding for evidence-informed initiatives, including anti-stigma and anti-bullying programs, to assist schools in supporting students' mental health and wellbeing.

12.5 Reforms to infant, child and family mental health and wellbeing services

Creating the new infant, child and family mental health and wellbeing service stream will require actions from many members of the Victorian community. This includes families, carers and supporters, the Department of Health and clinicians and service providers, from within and beyond the mental health sector.

These reforms reflect those the Commission considers will have the most impact. They are targeted to addressing the biggest gaps in current services. Reforms are grouped into three areas:

- support for parents, carers and supporters
- establishing Infant, Child and Family Local Health and Wellbeing Services
- reforming and expanding Infant, Child and Family Area Mental Health and Wellbeing Services.

The Commission does not consider there is a strong enough need to increase acute inpatient capacity for 0–11-year-olds. The Commission has prioritised investments in community-based treatment, care and support, including establishing subacute residential inpatient centres for the first time in Victoria. If there is a need for more acute inpatient capacity in the future, the Department of Health should consider introducing Hospital in the Home as a direct substitute for an acute inpatient admission in a hospital. Hospital in the Home is described in more detail in Chapter 10: *Adult bed-based services and alternatives*.

12.5.1 Support for parents, carers and supporters

Children develop within an environment of relationships that starts with their parent(s), carers and supporters.[101] These relationships affect virtually all aspects of their development—intellectual, social, emotional, physical and behavioural. The quality and consistency of these relationships lays the foundation for a wide range of outcomes later in life, including mental health and wellbeing.[102]

For children in the early years, having a relationship with a parent, carer or supporter who is stable, available, responsive to their needs and able to help them work through developmental stages and recover from traumatic experiences, is an important factor in their emotional development.[103]

Research suggests that children's mental health and wellbeing is strengthened when parents, carers and supporters get help to implement warm and consistent parenting practices, especially during difficult circumstances, and to maintain their own good mental health.[104] Although it is natural to assume that good parenting automatically flows from a parent, carer or supporter simply caring about their child, research suggests that effective parenting requires specific skills and involves particular practices.[105] While some parents might have reservations about seeking support for their parenting, many more are likely to welcome the support, with examples of programs with high take-up and positive feedback from parents.

Children under 12 generally do not seek help for their emotional, behavioural, developmental and mental health and wellbeing challenges; it is their parents, carers or supporters who tend to seek help on their behalf. The attitudes and literacy of parents, carers and supporters about mental health and wellbeing challenges can have a direct impact on if and how they seek help. Unfortunately, however, many parents do not feel equipped to respond to potential mental health and wellbeing problems in their children. For example, the national Child Health Poll, undertaken in July 2017 by the Royal Children's Hospital, surveyed 2,032 parents of children aged 0–18 years and showed that:

- only 35 per cent of parents surveyed were confident they could recognise the signs of a mental health problem in their child
- about one-third (35 per cent) of parents surveyed thought that mental health problems in their children might be best left alone to work themselves out over time
- only 44 per cent of parents surveyed were confident they would know where to go for help if their child was experiencing social, emotional or behavioural difficulties.[106]

In the future infant, child and family mental health service stream, there will be an increased focus on supporting parents, carers and supporters to build positive relationships with their children. This focus will be through a range of parenting supports including evidence-based parenting programs. Clinicians and support workers will work alongside parents, carers and supporters to increase their skills and confidence to effectively identify and support emerging mental health and wellbeing challenges in their children, and to effectively parent challenging behaviour.

This responds to evidence the Commission heard from families, carers and supporters that they want to be better supported. One parent told the Commission:

> Education should be provided to families and carers to help them give support and respond to behaviours of family members with mental illness in a therapeutic way. If I had this education to start with, our relationship would have been stronger earlier and harm would have been avoided.[107]

Parents, carers and supporters also said that they can feel judged by clinicians and support workers for their parenting abilities. Future services will focus on delivering supports in a non-judgemental, evidence-based way. For example, one parent told the Commission:

> I presented with my daughter at [child and youth mental health services] and I was told you're her mother and should know how to look after her.[108]

Another parent told the Commission:

> everything that happened ... was because I pushed it, and pushed it and pushed it and pushed it and when that happens, the clinicians then think that you're the one with the problem. But the problem is nobody's actually seeing the problem because nobody lives with it except you.[109]

These parenting supports will empower parents, carers and supporters in their important roles. The supports will also aim to harness their strengths and build new ones, via a collaborative approach.

As Ms Anne Hollonds, Director of the Australian Institute of Family Studies, noted:

> Support for effective parenting is about empowering parents, not blaming them … [and empowering] parents to be the best mum or dad they can be.[110]

Research suggests that parenting programs are effective. A 2020 VicHealth Evidence Review suggested there is:

> strong and consistent evidence that … parenting programs can improve parental mental health, enhance parent-child interactions, and promote positive parenting and family environments, and [that] this in turn can prevent the occurrence of child and adolescent mental health conditions.[111]

The findings of a 2018 systematic review also suggest that parenting programs do well in supporting emotional and behavioural challenges in children, as well as enhancing the wellbeing of parents.[112]

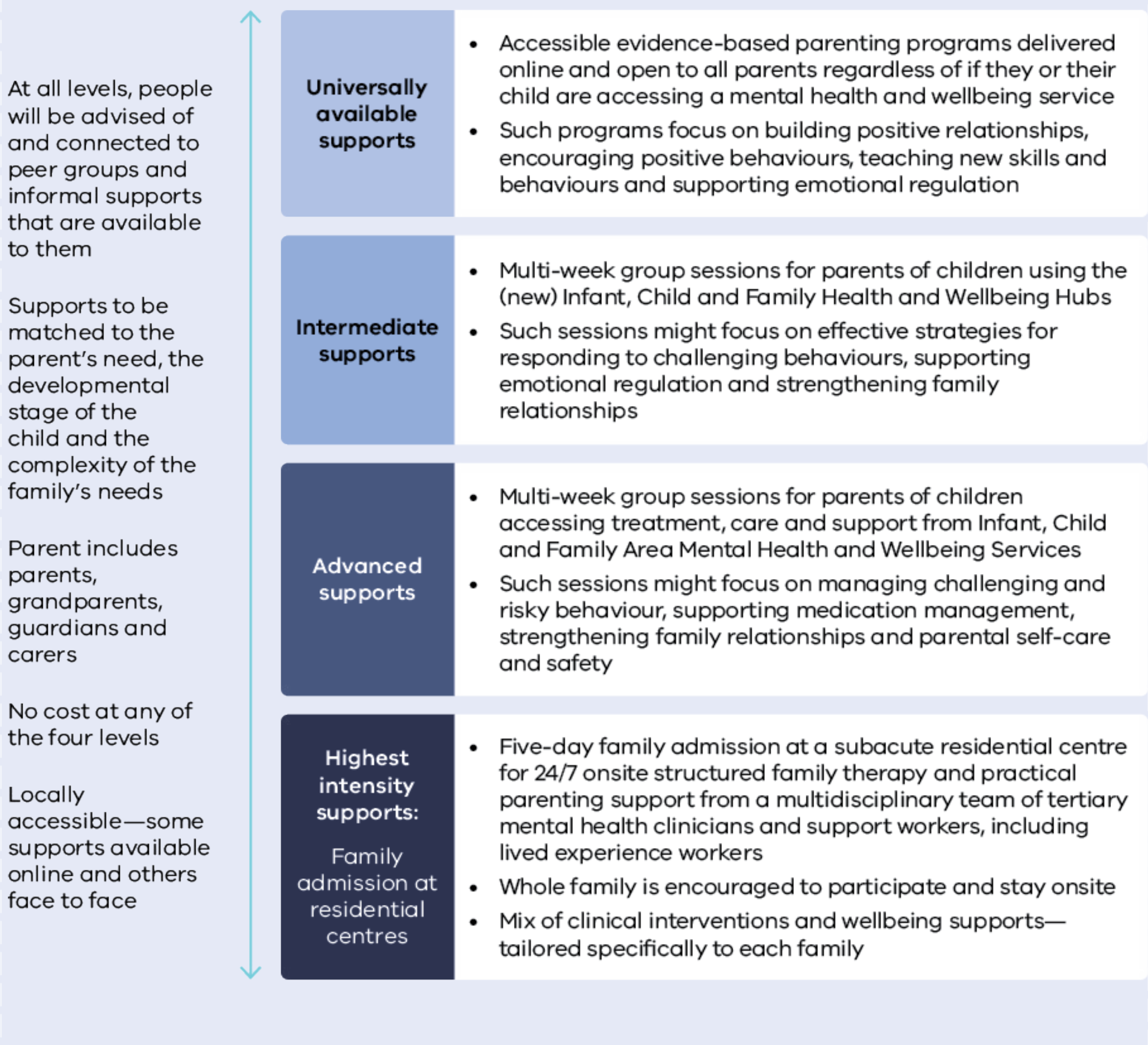
Supports for parents, carers and supporters will be provided at Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services, with the intensity and focus of the supports matched to parents, carers and supporters' needs. Matching the intensity of parenting supports to the behaviours and context of the infant or child helps determine how effective the supports will be. One parent whose two boys were receiving care from the mental health system shared her story of parenting supports that were not matched to her situation or needs:

> you put eight weeks of your life into turning up for two hours on a cold night. You walk away and think, oh, for goodness sake. And every one of those courses that I went to, they all were parents who said, 'oh, you know, my child's defiant, my child doesn't do this'. And I'm saying I've had 25 triple zero call outs this year. And I've, you know, had to disarm my son and he's tried to set fire to the house …. I was just a fish out of water there.[113]

To ensure parenting supports are matched to parenting needs, as set out in Figure 12.8, the Department of Health will establish a range of parenting supports through:

- continuing to make free, evidence based online parenting programs available to parents, carers and supporters across the state, with child health and wellbeing services to widely promote the parenting programs
- providing group-based parenting sessions to the parents, carers and supporters of children who are being seen in Infant, Child and Family Health and Wellbeing Hubs
- providing group-based parenting sessions to the parents, carers and supporters of infants and children who are accessing care in Infant, Child and Family Area Mental Health and Wellbeing Services
- establishing two statewide subacute residential family admission centres located in the community. These centres will provide five-day admissions in an intensive therapeutic environment for families with a child aged 0–11 years who is experiencing major behavioural, emotional and relationship difficulties.

Figure 12.8: Graduated parenting supports



New statewide subacute residential family admission centres

The new statewide subacute residential family admission centres mentioned earlier will provide families in distress with access to treatment, care and support in a safe, supportive, residential setting located away from hospitals. These will be the first centres of their kind in Victoria and will offer support to families that has to date not been provided.

In the future system, there will be two centres established across Victoria—one in metropolitan Melbourne and a second in regional Victoria. Regarding the centre in metropolitan Melbourne, in the 2016–17 State Budget, $7.3 million was allocated for a new Statewide Child and Family Mental Health Intensive Treatment Centre.[114] Austin Health has developed a Detailed Clinical Model of Care for this service.[115] The Commission considers the Department of Health should run an expression of interest process to determine the location and provider of the regional centre.

The family centres will have an early intervention focus. Accordingly, they will support infants and children who, without an admission, would potentially need an acute inpatient stay at some point in the future, as their mental health challenges escalate and become more complex. A five-day admission will enable mental health clinicians and support workers to better understand (through observation, assessment and therapy) the underlying causes of the mental health and wellbeing challenges the family is facing. The service will work with the family (however it is made up) to provide intensive individual and family therapy, including trauma-informed care.

Based on the model adopted at Coral Tree Family Service in Sydney (refer to case study), the family centres will operate within the following parameters:

- Co-designed with families, the centres will be welcoming and family friendly. The accommodation at each centre will be arranged to support multiple families to live there day to day.
- The five-day Monday to Friday admissions will be for the entire family (on an opt-in basis), with parents, siblings and other caregivers highly encouraged to participate. Treatment, care and support will be provided by multidisciplinary teams, including family peer workers.
- The centres will be networked and follow a broadly consistent model of care, with mechanisms to facilitate joint learning and evaluation.
- Given they are a bed-based services for children and families with intensive support needs, Infant, Child and Youth Area Mental Health and Wellbeing Services will operate the centres.
- The centres will provide post-discharge follow-up and warm referrals to continuing supports for the infant or child and their family, carers and supporters.

The Commission is also recommending an equivalent third service exclusively for Aboriginal families. As described in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*, the Victorian Government will fund the Victorian Aboriginal Community Controlled Health Organisation, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports.

Austin Health has progressed development of its Detailed Clinical Model of Care through a broad consultation process, including with Aboriginal organisations, identifying that intensive family admissions are 'a chance to genuinely contribute to closing the gaps in health outcomes for Aboriginal peoples'.[116] As Austin Health consulted on the proposed model of care for the centre,

> [t]here was considerable support for the [model of care] to meet the needs of Aboriginal people, but a recognition that this would need to start with a deep listening and learning alongside Elders, Aboriginal healers and those in leadership roles who could co-design aspects of the model with us.[117]

The process of working with Aboriginal organisations and families to self-determine how the Aboriginal family service would operate, including how it could build on the model of care that will be adopted for the metropolitan and regional centres, reflects the Commission's commitment to supporting the social and emotional wellbeing needs of Aboriginal Victorians.[118]

12.5.2 Establishing Infant, Child and Family Local Health and Wellbeing Services

Unlike youth mental health, where the Commonwealth has funded a network of headspace centres, there is no headspace equivalent for 0–11-year-olds. Many clinicians, service providers and academics told the Commission about the consequences of this for infants and children, and the system more broadly. This included:

- creating a 'missing middle' in the structure where infants and children miss out on treatment, care and support because the issues they experience are too complex to be managed by GPs, paediatricians and maternal and child health nurses but not complex enough to meet the high threshold for child and adolescent mental health services or child and youth mental health services
- referring infants and children from primary care straight to child and adolescent mental health services or child and youth mental health services, creating significant demand pressures from infants and children who could be appropriately seen at a secondary care level. These infants and children will then sometimes be refused care or, due to demand pressures, face a long wait for their first appointment.

Dr Richard Haslam, Director of Mental Health at the Royal Children's Hospital, emphasised the effects of an incomplete system of treatment, care and support:

> An important missing part of the service system to support mental health and reduce mental disorders are community paediatricians and community hubs (similar to headspace) where children and adolescents and their families can visit to find out more about mental health problems, other health problems and other family difficulties … Community hubs with family, welfare, paediatric and child and adolescent mental health services should be piloted to emulate the 'no wrong door' philosophy of headspace, support for families and the position that mental health is a core part of general health.[119]

Case study:

Coral Tree Family Service

Coral Tree Family Service offers a four-night intensive family residential program to assist the families of children with mental health, behavioural, emotional and relationship difficulties. The entire family (everyone living in the same household as the referred child) attends the program. It has been operating in its current form for 20 years, providing a service to families across New South Wales.

Cathryn McElroy, Service Manager at Coral Tree, said it is a unique model that focuses on elements of family therapy, parent management training and attachment-informed interventions.

> It is the only organisation of its kind in Australia to offer a residential service—the most unique part about spending a week at Coral Tree is the chance to have in-the-moment observation and coaching. Staff are present at community activities, mealtimes, points of transition and family fun time, to both observe and provide assistance.

Ms McElroy added that children and families admitted to the service have already had significant outpatient family, parenting and psychiatric input, and that four nights in the program can effect change.

> We find a one-week admission to be long enough to make some changes, with a significant burst of intensive input, and short enough to maintain the focus of family and staff, and not get too ahead of the 'reality' of the need to return home to put things into practice.

Dr Matthew Symond, Clinical Lead at Coral Tree, said the program makes no assumptions or determinations of who is in a child's family, which can include parents, carers, grandparents and siblings.

> They define the family—but we request that parents or carers and/or other members attend for the treatment. If the parents are separated, they access the service separately. The key to the success of the program is the continuity of people involved in the treatment.

Treatment is provided by a multidisciplinary team that includes a child and adolescent psychiatrist, nurses, psychologists, social workers and peer family workers. Staff support parents as situations are occurring by checking in, offering thoughts about what strategies could be used, and assisting parents when managing any risks. According to Tamar Karkour, Clinical Psychologist at Coral Tree, this coaching can be as little or as much as the parents like, as staff are guided by the parents' preferences.

Photo credit: Cathryn McElroy

> Clinical staff actively coach parents in moments that present a challenge for them in their daily life. For example, a child refuses to take medications, getting dressed for school or any other stressors in the day. How to outlast an escalation, support a parent to enforce strategies such as time out, and praise them healthily, are all aspects of coaching for the parent that this model offers.

The Lawson family spent five days in the program to support their 10-year-old son Adrian and said the help they were given was invaluable.

> This is our second visit to Coral Tree ... If you had told us six months ago that life could begin to be almost normal, we would not have believed it. Adrian has behaviour problems, which escalate to violent outbursts and end with someone getting hurt ... We have been given so much help, advice and encouragement here. We learnt that [my partner] and I also had many things that needed to change, to help Adrian and bring us together as a family. It is very hard to change ten years of 'life', but we are doing it. Step by step. [We] now feel that we are able to be 'parents'.

Source: RCVMHS meeting with Coral Tree Family Service, March 2020; Peter Krabman and others, *Intensive inpatient family work with families of children with emotional and behavioural difficulties: an Australian experience.*

Building on the emerging experience of Barwon Health's Child and Family Services Hub (refer to case study), the Department of Health will establish three initial Infant, Child and Family Health and Wellbeing Hubs, with the following characteristics:

- The hubs will take a one-stop shop approach to child health by prioritising infants and children with emotional (for example, mental health challenges), developmental (for example, intellectual disability, autism spectrum disorder, speech delay) and physical health challenges (for example, asthma, allergies, chronic disease) that have continued to affect their wellbeing despite previous support.
- There will be a low threshold to entry, with no diagnosis of mental illness or a referral needed for infants and children to be eligible.
- The hubs will use a whole-of-family approach, including working with the child and their parents, carers and supporters on building skills and knowledge that can be applied at home. Clinicians at the hub will coordinate services around the child and family, and actively work with the full range of care providers involved with the child to build a cohesive network of support around the family.
- Assessments for a range of conditions will be provided as needed, including for autism, as well as group-based parenting sessions for parents and caregivers of children being seen in the hubs.
- Infant, Child and Family Area Mental Health and Wellbeing Services will provide backup for each hub, with clinicians providing second opinions, limited shared clinical care and capacity building. Tertiary clinicians in child health more broadly may also provide support, such as paediatric services. This will mean these hubs provide an avenue for people who need to access publicly funded paediatricians, psychologists and psychiatrists.
- The locations of the three hubs will be informed by considerations of equity, taking into account the distribution of current services and taking advantage of existing infrastructure including community health centres.
- A range of other services families use will be integrated in the one location, including GPs, paediatricians, Medicare-billed private psychologists and psychiatrists, social workers, speech pathologists and occupational therapists.
- The three new hubs, along with the existing hub at Barwon, will form a network to develop a consistent model of care and so that lessons can be shared.

Historically, the Commonwealth has funded these sorts of 'secondary care' style services, such as the national network of headspace centres and the HeadtoHelp clinics. The Commission notes that the draft *National Children's Mental Health and Wellbeing Strategy* endorses a model of integrated child and family care at multiple locations across Australia, which is very similar to these hubs.[120] By working closely with the Commonwealth Government, Victoria's three new hubs could potentially become the early adopters of this model of integration. The Victorian Government should invite the Commonwealth Government to form a partnership to develop the three hubs, with the aim of rolling them out progressively across Victoria.

12.5.3 Expanding and reforming Infant, Child and Family Area Mental Health and Wellbeing Services

Most infants and children will receive treatment, care and support in primary and secondary mental health and related services or in the newly established Infant, Child and Family Local Health and Wellbeing Services (where available). For infants and children who need higher intensity multidisciplinary treatment, care and support, the expanded service stream of Infant, Child and Family Area Mental Health and Wellbeing Services will provide a developmentally appropriate model of care.

Eastern Health described the infants and children who meet the criteria for their area-level service:

> [They] typically have highly complex presentations including experiences of significant trauma, family violence, severe attachment difficulties, and parental mental illness ... without collaborative engagement with families and the system of care, including Child Protection, Child First, Maternal Child Health Nurses, schools, to name a few, outcomes are poor, leading to family breakdown, school disengagement and poor future prognosis.[121]

Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, Alfred Health, who gave evidence in a personal capacity, described their role as providing multidisciplinary care. Infants and children who are eligible for the service have needs that are too complex for a single clinician to effectively manage:

> I guess we employ at CYMHS [child and youth mental health services] a broad range of disciplines, and we're very focused on trying to make sure that, where they're sort of equally represented, so we have an equal number of nurses, psychologists, [occupational therapists], social workers and doctors, because it's about, if the mandate for CYMHS is for people who need a multidisciplinary response, so we need to have a multidisciplinary team to do that.[122]

Dr Liam O'Connor, Child and Adolescent Psychiatrist at Bendigo Health's Child and Adolescent Mental Health Service, also described the importance of multidisciplinary care:

> A distinctive feature of CAMHS [child and adolescent mental health services] is the multidisciplinary nature of the service. The involvement of psychologists, occupational therapists, social workers, family therapists, psychiatrists, child psychotherapists and speech therapists is vital in making a difference with moderate to severe mental health difficulties for pre-schoolers, children and adolescents.[123]

Competencies in working across multiple agencies is also important to area-level clinicians and support workers being able to provide treatment, care and support that is relationally and trauma-informed. Dr Denborough stated that:

> I guess as we've become more and more a service of last resort ... there's a lot more working with other agencies, like child protection or youth justice.[124]

Case study:

The Child and Family Health Service at Barwon Health North

In September 2020, Barwon Health established the Child and Family Health Service at the newly built community health facility in North Geelong. The service is designed to help children from before birth to preschool with developmental delays and vulnerabilities. Unlike similar developmental paediatric services around Australia, psychiatry is formally included within the multidisciplinary team.

Dr Ben Goodfellow, Perinatal, Infant and Child Psychiatrist and Psychoanalyst at the service, noted the importance of embedding mental health services in paediatric care.

> For several decades there have been many barriers to helping families who could benefit from what infant mental health has to offer—firstly, a lack of experienced infant mental health clinicians and services, but also the very siloed nature of health services. The integration of care that comes from being directly in the paediatric setting provides the opportunity to treat, teach and guide practice that colleagues from all health disciplines in my field have been advocating for.

Dr Goodfellow observed that while youth mental health services have grown, many obstacles to young children receiving treatment remain.

> From the perinatal period to preschool, children and families are often unable to access specialist mental health care, not only because of scarce resources, but also because of a lack of awareness and understanding in the broader community, that babies and young children can be engaged in mental health treatment no less than people of any other age. Importantly, mental health problems in young children so often present with physical symptoms, and so the system stays focused on a medical solution, when in fact the mind and body are very much intertwined but require different expertise.

Dr Goodfellow said the Child and Family Health Service's integrated approach enables it to address the multiple determinants of a child's wellbeing.

> The integrated design recognises the powerful connections between the social, emotional and family determinants of a child's development, health and wellbeing. It unifies support for the psychic, relationship-based, and physical needs of babies and children by working with families where they are at, while keeping the baby or child in mind as a person in their own right and at the centre of care.

Embedding psychiatry in the multidisciplinary team assists in breaking down some of the most common barriers to comprehensive, integrated care. Paediatrician and director of the service, Dr Chris Cooper, spoke of the benefits of working closely with colleagues from other disciplines.

> I learn so much from working alongside my child psychiatry colleague in real-time. Child psychiatry's involvement in community paediatrics should be 'business as usual' not an occasional extravagance.

One of the service's speech pathologists explained how having a connection to psychiatry can assist in providing better treatment and support.

> I've often recognised that the feeding problems in infants I see is about much more than just the mechanics of it all. Now, through discussions with the psychiatrist, I'm learning how to include the family's background story and their mental health in my understanding and treatment.

Referrals to the service can come from primary, secondary or tertiary providers, childcare centres and directly from families themselves, ensuring ease of access.

From a total staff of around 14 fulltime employees, the formal mental health component of the service includes a perinatal, infant and child psychiatrist one and a half days per week, and two child psychologists. Other medical and allied disciplines are supported closely in the mental health elements of their work. Dr Goodfellow said:

> The integration allows for a shared approach to case planning, decision making, governance and clinical supervision. This includes oversight from senior clinicians, and the ability for more complex cases to receive direct and indirect input from psychiatry. This rolling process of professional development sees clinicians expanding their understanding and ways of working beyond the expertise of their primary discipline, with increasing sophistication in the therapeutic, psychosocial and parent-guidance elements of their work. It's very inspiring to see.

Founding principles of the service include making those children most in need—such as those in and out of home care and others known to be at high risk for treatable developmental delays—a priority and working in community settings where possible. Concepts of the 'First 1000 Days Program' inform much of the clinic's work, recognising that a child needs coordinated networks of love, care, learning, support and clinical treatment to flourish.

Pending positive evaluations of the Child and Family Health Service's models of care and effectiveness, Barwon Health plans to expand it across its entire service area.

Source: Dr Ben Goodfellow, *Correspondence to the RCVMHS*, 2020.

Like Adult and Older Adult Area Mental Health and Wellbeing Services, Infant, Child and Youth Area Mental Health and Wellbeing Services will be delivered through partnerships between a public health service or public hospital and a non-government organisation that provides wellbeing supports. Infant, Child and Family Area Mental Health and Wellbeing will be delivered as a stream of services within this arrangement.

Based on the evidence received, the Commission has determined that transforming Infant, Child and Family Area Mental Health and Wellbeing Services comprises two interconnected reforms:

- increased access to treatment, care and support to ensure infants and children with the most complex needs are not turned away
- expanding their scope to align with the community mental health and wellbeing services' core functions, including changes to the way area services can be accessed, so that infants and children are initially supported through primary and secondary care, except for crisis pathways.

Infant, Child and Family Area Mental Health and Wellbeing Services also need to reflect the diversity of Victorian infants and children. They must ensure their services are accessible and responsive to all types of diversity. Examples of changes that may be needed include increased workforce diversity (for example, employing Aboriginal mental health clinicians or liaison officers), reviewing the cultural appropriateness of consumer information and implementation of additional supports for specific groups in their communities based on need. They will also need to form partnerships with the new Social and Emotional Wellbeing Teams in Aboriginal communities, which were recommended in the Commission's interim report.[125]

Each of the Infant, Child and Youth Mental Health and Wellbeing Services will substantially increase the numbers of family peer workers they employ. Family peer workers will work directly with families, carers and supporters, orienting them to the service, providing emotional support and guiding them through their journey with the service. This will include care planning and coordination of their non-clinical needs and regular check-ins between appointments. Although some child and adolescent mental health services and child and youth mental health services already employ family peer workers, this is not standard practice across the system and, when employed, family peer workers are often in advisory roles only.

Services will also need to formalise family, carer and supporter participation in their advisory structures, such as through family advisory councils and other formally recognised structures. While some services already have these structures in place, the Commission understands that not every service does. This ensures that families, carers and supporters are embedded in governance and advisory structures at multiple levels, noting their inclusion in the new service standards for selecting and funding providers, as set out in Chapter 28: *Commissioning for responsive services*.

Increased access to treatment, care and support across Victoria

The high threshold that infants and children must currently meet to access child and adolescent mental health services or child and youth mental health services, even when other services have already assessed them as needing specialised multidisciplinary care, was consistent in the evidence the Commission received. This included evidence from the Australian Medical Association (Victoria), which said that:

> Over time the threshold for access to tertiary care has increased substantially. Due to inadequate public mental health services, many patients in need of care who could benefit from child and youth programs are in fact turned away from services like CAMHS [child and adolescent mental health services] /CYMHS [child and youth mental health services].[126]

Clinicians also emphasised the high threshold, with Dr Denborough observing 'often a lot of time is spent working out why people can't come in rather than actually just seeing someone'.[127]

The Commission also heard directly from families. One parent who was caring for her suicidal daughter told the Commission:

> I called the triage number they gave me for the [child and adolescent mental health services] to try and get a 72-hour appointment and avoid the emergency department. I had to go through our story again. They said they would check if there was a bed. No one rang back. I waited all day for someone to call.[128]

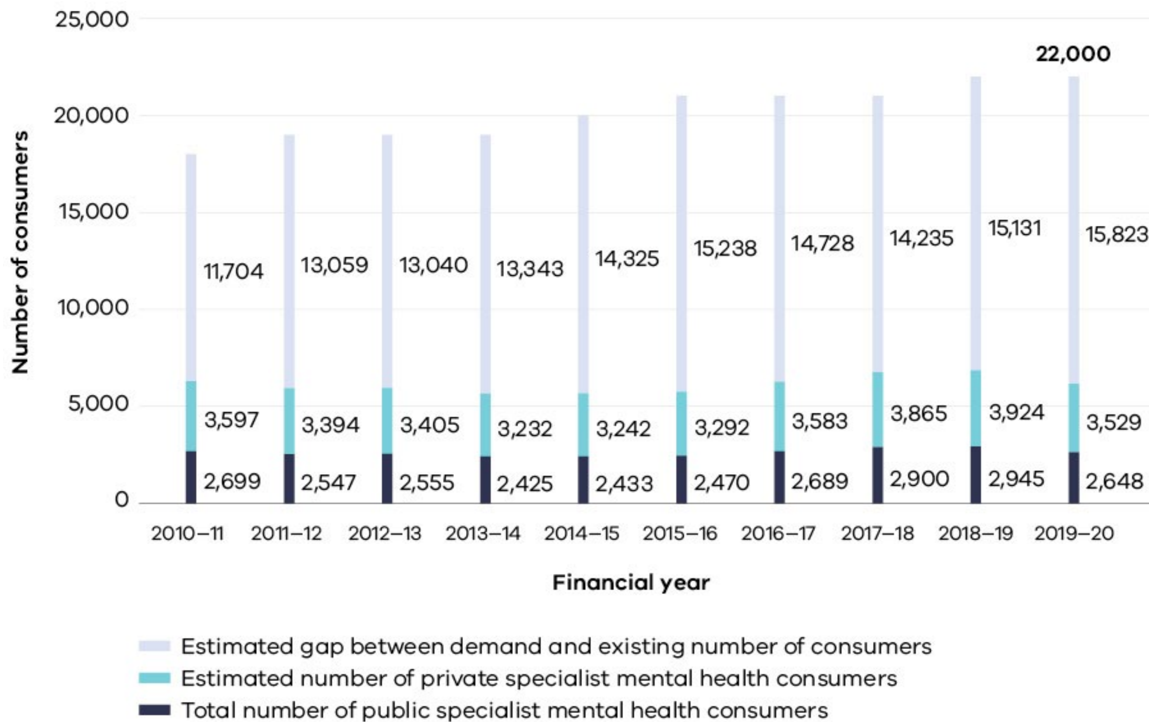
Another mother whose two sons were being helped by child and youth mental health services described her experience trying to get help as, '[t]his whole thing is a lottery driven by crisis. That is how I would describe the system.'[129]

Analysis of data undertaken by the Commission aligns with the evidence received about how difficult many families find it to access help from child and adolescent mental health services or child and youth mental health services. As shown in the first graph in Figure 12.9, there is a very substantial gap estimated between the number of infants and children needing specialist mental health services and the amount that has been provided. In 2019–20, including private sector services, it is estimated that 15,823 infants and children needed, but did not access, specialist mental health services.

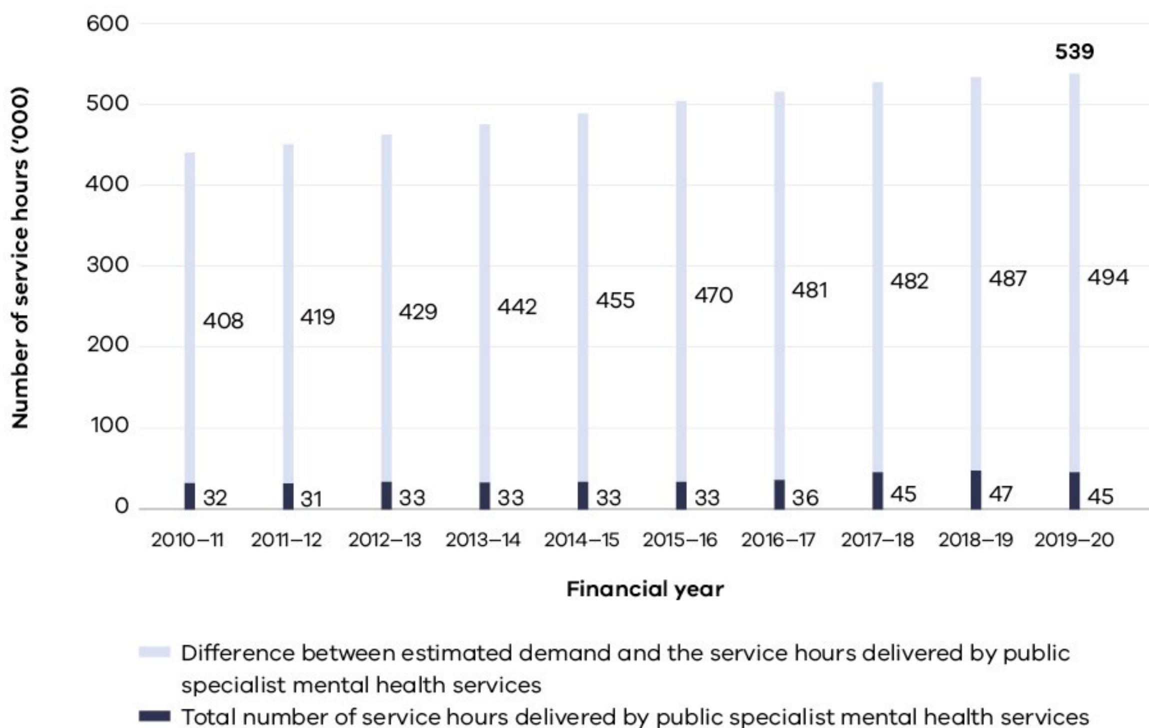
While the first graph indicates the number of infants and children accessing specialist services, the second considers the amount of community-based specialist services, in terms of 'service hours' infants and children accessed. It shows that of the estimated need for 539,000 community service hours in 2019–20, only 45,000 were delivered by the public system. While some of that gap was likely supported by private services, there remains a stark under-supply for community-based infant and child mental health services that must be addressed.

Figure 12.9: The difference between the actual number of people receiving specialist mental health services/actual consumer-related community service hours delivered and estimated demand, 0–11 years, 2010–11 to 2019–20

A. Consumers



B. Service hours



Sources: A. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2018–19; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18; Australian Institute of Health and Welfare, Mental Health Services in Australia: Medicare Subsidised Mental Health-Related Services 2018–19. Table MBS.2.

B. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

A. The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology.

This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store, which in 2019–20 was 16 per cent of total contacts. Unregistered contacts are higher for consumers aged 0–11, which in 2019–20 was 35 per cent of total contacts.

For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers in 2019–20. As the two estimates were similar, they have not been included in this figure.

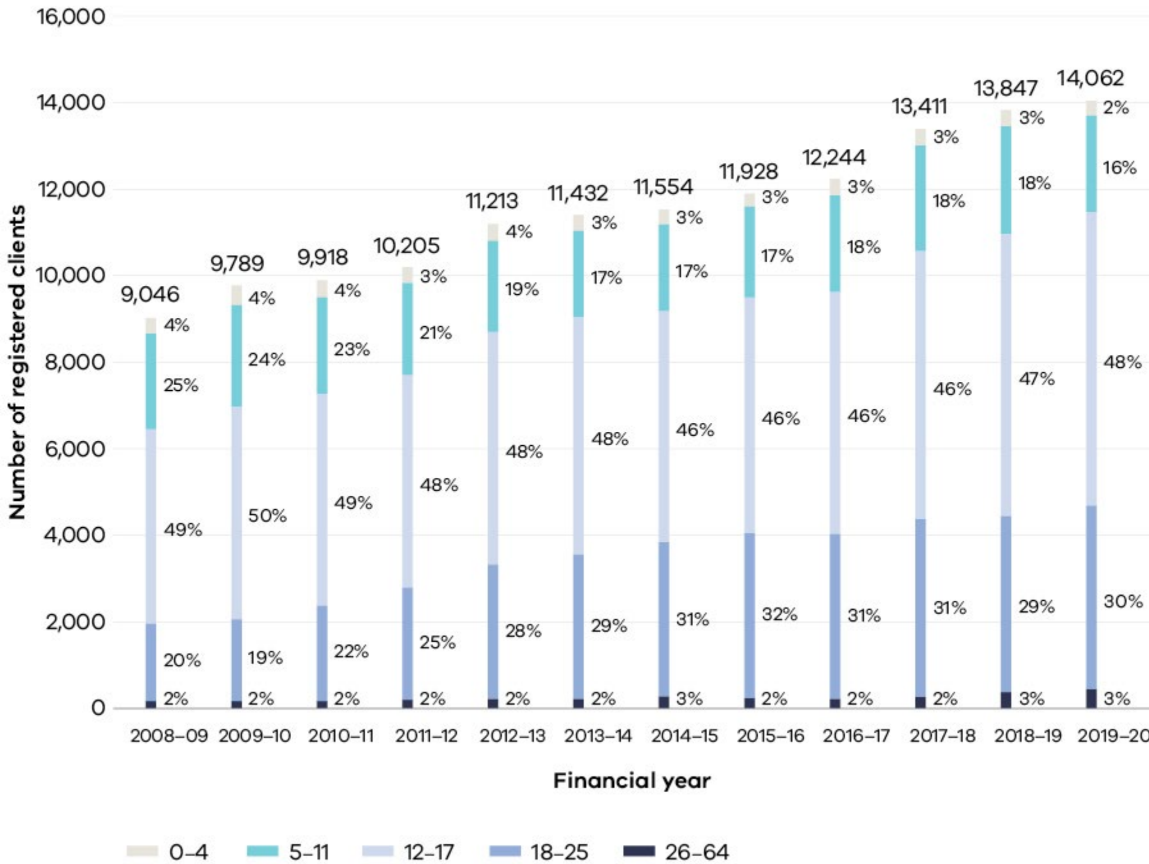
B. Some of the gap may be met through services delivered in the private mental health system. Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity, for example assessment, monitoring, and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

In addition, the Commission also heard that, in the current system of services supporting people aged 0–18 and 0–25, resources are often directed away from infants and children to help adolescents and young people. Adolescents and young people tend to present to services with more acute behaviours, including suicidal behaviour and psychosis, which need more immediate attention due to risks to themselves and others. This skewing of resources is evident in Figure 12.10, which indicates that infants and children aged 0–4 years and 5–11 years represent a smaller proportion compared with older age groups in 2019–20 (18 per cent compared with 81 per cent).

Clinicians working in child and adolescent mental health services or child and youth mental health services confirmed this, noting that demand pressures drew resources away from infants and children. Dr Haslam commented that:

> CAMHS [child and adolescent mental health services] provide services to 0 to 18 year olds, but there has been little attention to those aged 4 years and below until about 10 years ago. Even now, most patients at CAMHS are school-aged children, and there has been a general neglect of infants and pre-schoolers with mental illnesses, which reflects community reluctance to acknowledge that infants and pre-schoolers can suffer significant emotional stress and disorders.[130]

Figure 12.10: Number of child and adolescent mental health service / child and youth mental health service registered clients, by age group, Victoria, 2008–09 to 2019–20



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store 2008–09 to 2019–20.

Note: Includes Orygen-registered clients. Percentages may not total 100 due to rounding.

As well as the access issues outlined earlier, the Commission also heard from families that after being accepted as needing help from child and adolescent mental health services and child and youth mental health services, they then waited long periods to receive therapy. One parent told the Commission:

> When Natasha has reached out for help, I have seen that she has been rejected, or that she has to wait ridiculous amounts of time to get help that is usually too little, too late.[131]

With treatment, care and support designed to be proportionate to people's needs in the future service stream, the Commission considers there are five streams of people with broadly similar needs that need help with mental health and wellbeing challenges. These five streams, which are referred to as consumer streams-are outlined in Figure 12.11. These streams are not intended to imply that all infants and children within each of the streams have the same experiences and needs, rather they help planners to consider the differentiated support needs that exist and services to adapt their support to people's varying needs.

Figure 12.11: The estimated number of people requiring mental health treatment, care and support over a 12-month period, by stream, aged 0–11, Victoria, 2020–21

At any given point in time, a person living with mental illness or experiencing psychological distress will need to be able to access treatment, care and support in one of five intensity-based streams:	Estimated number of people aged 0–11 in 2020–21
Communities and primary care stream	**147,000**
Primary care with extra supports stream	**36,000**
Short-term treatment, care and support stream	
Ongoing treatment, care and support stream	**22,000**
Ongoing intensive treatment, care and support stream	

Source: Commission analysis of the Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Department of Environment, Land, Water and Planning, *Victoria in the Future 2019*.

Notes: Streams are adapted from Harvey Whiteford and others, Estimating the Number of Adults with Severe and Persistent Mental Illness Who Have Complex, Multi-Agency Needs, *Australian and New Zealand Journal of Psychiatry*, 51.8 (2017), 799–809. Care profiles from the *National Mental Health Service Planning Framework* have been mapped to the streams.

Due to their young age, the distinction between the streams of short-term treatment, care and support, ongoing treatment, care and support and ongoing intensive treatment, care and support for infants and children is less significant than in older age groups. Therefore, the estimated numbers of people needing this level of support has been shown collectively, whereas in other age groups it is separated out. More detail on how the streams were developed is located in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*.

In the future system, the estimated 22,000 infants and children in the short-term, ongoing and ongoing intensive treatment, care and support streams will be able to access their treatment, care and support from a combination of Infant, Child and Family Local Health and Wellbeing Services (the Infant, Child and Family Health and Wellbeing Hubs) and Infant, Child and Family Area Mental Health and Wellbeing Services.

In the three areas that have Infant, Child and Family Health and Wellbeing Hubs, it is expected that some of the 22,000 infants and children in the three highest intensity streams will receive their help from these three new services.

To improve the accessibility of treatment, care and support and address the quality of care issues raised, significant and ongoing investment in Infant, Child and Family Area Mental Health and Wellbeing Services will be required to bridge the gap between the numbers of infants and children services are currently seeing and the 22,000 infants and children estimated to need help (2,648 infants and children were helped in 2019–20).[132]

In addition to a service expansion, the Department of Health will work with Regional Mental Health and Wellbeing Boards to determine the optimal longer term funding levels for the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services through the needs assessment, demand modelling and planning process recommended by the Commission in Chapter 28: *Commissioning for responsive services*.

As noted earlier, the Commission heard that services are diverting funding from 0–11-year-olds to help older children and young people who present needing more immediate attention. The introduction of activity-based funding and a new performance and accountability framework will hold services accountable for providing and maintaining services equitably across the different age groups.

Expanding the scope of treatment, care and support

In the future system, the scope of community-based Infant, Child and Family Area Mental Health and Wellbeing Services will be expanded to align with the Commission's community mental health and wellbeing services' core functions (refer to Figure 12.3).

These core functions are introduced in Chapter 5: *A responsive and integrated system*, and explained in detail in the context of adult services in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

They set the Commission's expectations for the community-based care infants and children should access in a contemporary, evidence-based system. They will be delivered consistently across Infant, Child and Family Area Mental Health and Wellbeing Services. This will increase the consistency in type and range of help that infants and children can access, regardless of where they live and, enable a much broader range of services to be delivered to better meet their needs.

The range of ways that Infant, Child and Family Area Mental Health and Wellbeing Services deliver the core functions will also be expanded so help can be provided more effectively and in different ways.

While clinic-based services will still be the main way that care is accessed, the Commission heard that standard operating hours of 9:00 am to 5:00 pm on Monday to Friday can make access hard for families. One reason is that children often need to miss school to attend appointments, which can be disruptive and stigmatising. One parent spoke of the impact standard operating hours has had on her child:

> my daughter was already eight months behind in schooling, so just pulling her out constantly to attend appointments, was causing further stress to her, further stress to me and yeah, it was just a really, really difficult time.[133]

Infant, Child and Family Area Mental Health and Wellbeing Services will explore ways to increase the accessibility of their clinic-based services through a co-design process with families. This should include extending telehealth (where safe and the preference of the family) and operating days and times, with the aim of promoting family inclusion and supporting early learning and education and daily routines.

In the expansion of services outlined earlier, where possible priority should be given to co-locating the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services with or near other infant and child services families use. This includes maternal and child health nurse centres and early parenting centres.

Core function 1: Integrated treatment, care and support across four components

Under Core function 1, the range of services Infant, Child and Family Area Mental Health and Wellbeing Services deliver will be significantly expanded so they are much more holistic. As shown in Figure 12.3, Core function 1 contains four core components, each of which is explained below.

1.a: Treatments and therapies

While the Commission's reforms aim to achieve a balance between clinical mental health care and wellbeing supports, clinical treatment remains important. Clinical treatment will be strengthened, and the range of evidence-based therapies will be expanded in line with contemporary practice.

To provide infants and children with contemporary treatment, care and support, Infant, Child and Family Area Mental Health and Wellbeing Services will offer a broad range of therapeutic interventions and treatments. These will include psychological therapies, pharmacological therapies, family therapies, trauma-informed therapies, speech therapy, occupational therapy and arts and creative therapies. The choice of therapies will be informed by families' preferences and needs.

As well as therapy delivered directly to infants and children, family therapy that involves the infant's or child's support network needs to become standard practice in every service. While there are many evidence-based forms of family therapy (which vary in their approach, based on developmental stage), the Commission heard from clinicians, service providers and academics of the many benefits of single-session therapy.[134] The Commission considers that single-session therapy should be widely available in each service. More detail on single-session therapy can be found in the case study in Chapter 13: *Supporting the mental health and wellbeing of young people*.

As part of increasing the effectiveness of integrated treatment and therapies, newly established specialist trauma practitioners will support infants and children with trauma histories by becoming, where required, part of their multidisciplinary care team. Working alongside peer support workers, trauma practitioners will support children, families, carers and supporters to develop a therapeutic recovery plan that facilitates clinical and non-clinical options for treatment, care and support. As described in Chapter 15: *Responding to trauma*, these specialist practitioners will be embedded within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services, under the same clinical governance. They will also 'reach in' and support the three Infant, Child and Family Health and Wellbeing Hubs, as they are established.

To respond to the evidence of poorer physical health outcomes for people with mental illness, across all age groups, area mental health and wellbeing services will ensure they discuss and understand a person's physical health needs as part of care planning and coordination.[135] These discussions should occur at the initial intake stage and regularly throughout their treatment, care and support in case their needs change. Infant, Child and Youth Area Mental Health and Wellbeing Services will also proactively connect people they are helping to general practice, including GPs and practice nurses available in community health centres. The Commission is also aware that some of the existing area mental health services already employ physical health clinicians as part of their multidisciplinary teams, such as speech pathologists and exercise physiologists. The Commission encourages all services to consider the value of employing physical health clinicians in their teams.

As noted earlier, and in other chapters, Infant, Child and Youth Area Mental Health and Wellbeing Services will be expanded to better meet demand. This expansion is likely to mean that Infant, Child and Youth Area Mental Health and Wellbeing Services will need an expanded physical footprint. This provides an opportunity for co-location with other services people use, such as general practice, which would further encourage integration between mental and physical health.

To deliver the range of integrated treatment and therapies now expected as standard practice, services may need to increase the diversity of disciplines within their teams. This might include allied health professionals, family peer workers and music and art therapists.

1.b: Wellbeing supports (formerly known as psychosocial supports)

As described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, an objective of the Commission's work is to rebalance Victoria's mental health and wellbeing system so there is a balanced focus on clinical care and treatment and wellbeing supports.

Because of the nature of infants' and children's developmental stages and levels of independence, this component has less prominence for infants and children than in other age groups. The developmental and relational context in which treatment, care and support for infants and children is delivered already promotes a balanced focus between clinical and wellbeing supports. If infants and children and their families need wellbeing supports, these will be supported by the wellbeing supports available in the youth service stream of the Infant, Child and Youth Mental Health and Wellbeing Services.

1.c: Education, peer support and self-help

In addition to the range of parenting supports that will be implemented across the infant, child and family service stream (as described earlier), families, carers and supporters will also be able to access the recovery colleges (or discovery colleges) that are being established in Infant, Child and Youth Area Mental Health and Wellbeing Services. Further discussion on recovery colleges is in Chapter 13: *Supporting the mental health and wellbeing of young people*. This will support their understanding of a range of mental health and wellbeing challenges, as well as their capability to support their infant or child to manage and recover from mental health and wellbeing challenges.

1.d: Care planning and coordination

For some infants and children, comprehensive care planning and coordination in the current system can be limited, especially when there are multiple clinicians and agencies involved. The Commission heard that sometimes the coordination falls to the parent, carer or supporter. For example, one parent stated that:

> I have to organise these meetings and coordinate everyone's diaries. I work full-time, and I'm also trying to coordinate meetings with professionals.[136]

In the future system, infants and children with the most complex support needs will be offered comprehensive care planning and coordination that is proportionate to their own strengths and needs, as well as those of their family, carers and supporters. The care planning and coordination component will organise, plan and coordinate the support that infants and children will receive. As much as possible, the voice of the infant and child will be central to their care planning and coordination, with their needs and preferences reviewed periodically throughout the course of their treatment, care and support.

Care planning and coordination includes the front-end components of access and navigation support, initial support discussions and comprehensive needs assessment and planning discussions, as described in Chapter 8: *Finding and accessing treatment, care and support*.

One facet of comprehensive needs assessment and planning discussions is diagnostic assessment. As discussed in earlier chapters, while the future system will focus less on diagnosis than is currently the case, it will remain an important part of providing treatment, care and support. There are many diagnostic assessments that may be completed for infants and children.

One diagnostic assessment type that will continue to be undertaken by Infant, Child and Family Area Mental Health and Wellbeing Services is an autism spectrum disorder assessment. Access to timely autism assessments in the public mental health system is essential for infant or child development and the wellbeing of the family, carers and supporters. It also assists families to apply for autism-related supports in other systems that are diagnosis-dependent.

In the future system, Infant, Child and Family Area Mental Health and Wellbeing Services will address the unacceptable wait times for an autism assessment, which can be as long as nine to 22 months across services. Table 12.2 presents wait time information at a sample of health services. Where available, the new Infant, Child and Family Health and Wellbeing Hubs will also undertake autism assessments, which will assist in reducing wait times in the areas in which they operate.

The Commission also notes that comorbidity between poor mental health and autism is estimated to be high.[137] Research suggests at least 60 per cent of children with autism may have at least one diagnosable mental illness.[138] Mindful, the Centre for Training and Research in Developmental Health at the University of Melbourne, observed that co-occurring mental illness or psychological distress is increasingly the reason that infants and children with autism present to child and adolescent mental health services and child and youth mental health services.[139] It will be important that Infant, Child and Family Area Mental Health and Wellbeing Services ensure their multidisciplinary teams have appropriate capabilities to effectively work with infants, children and families where autism and mental health and wellbeing challenges co-exist.

Table 12.2: Estimated wait times to access the Autism Spectrum Disorder Assessment Program, Victoria, 2020

Alfred Health[1]	Austin Health[2]	Barwon Health	Bendigo Health	Eastern Health[3]	Latrobe Regional Hospital	Monash Health	The Royal Children's Hospital[4]	South West Healthcare
9 months	4 to 5 months	22 months	15 months	6 weeks	3 months	6 weeks	Specialist Autism Team – 15 to 16 months Community teams – 3 to 8 months General Medicine Team – 9 to 10 months	12 to 18 months

Sources: Alfred Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Austin Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Barwon Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Bendigo Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Eastern Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Latrobe Regional Hospital, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Monash Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; Latrobe Regional Health, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020; South West Healthcare, *Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services*, 2020.

Notes: 1. Wait time as at 2018; 2. Pre-COVID-19 average wait time. As at October 2020, the wait time is six to seven months; 3. Impacted by COVID-19. Pre-COVID-19 average wait time. COVID-19 wait time is six months. 4. The Royal Children's Hospital Mental Health service completes specialist autism spectrum disorder assessments through four separate clinical settings. The first is the Specialist Autism Team (SAT) based at RCH Parkville. The remaining three are community clinics where children are referred for various mental health concerns. Assessment can be conducted by these community teams where a diagnosis of autism is suspected in the course of the mental health assessment and interventions. The RCH Department of General Medicine also offers autism assessment via the Autism Multidisciplinary Assessment Clinic. Given the various presenting problems and comorbidities for children with autism, initial referrals may also be directed to other RCH clinics including those in the Centre for Community Child Health and Neuro Development and Disability. These clinics differentiate whether a specific diagnostic assessment for autism is required.

Counting methods and sampling approaches vary between health services and may not be comparable. Responses were provided to the Commission between August and October 2020, and services may have been partially or fully impacted by COVID-19.

Core function 2: Services to help people find and access treatment, care and support and, in area services, respond to crises 24 hours a day, seven days a week

While the Commission expects that most infants and children will be helped through primary and secondary care and the Infant, Child and Family Health and Wellbeing Hubs (where established), some infants and children will still need higher intensity support from Infant, Child and Family Area Mental Health and Wellbeing Services.

As described across all age-based systems in Chapter 8: *Finding and accessing treatment, care and support*, in the future system, access to Area Mental Health and Wellbeing Services will be managed more tightly through a new referral system. Unless infants and children are experiencing a crisis, they will need a referral from an Infant, Child and Family Health and Wellbeing Hub or a medical practitioner (such as GP, psychiatrist or paediatrician) in order to be helped by Infant, Child and Youth Area Mental Health and Wellbeing Services.

As explained in Chapter 9: *Crisis and emergency responses,* Area Mental Health and Wellbeing Services will respond to requests for crisis assistance from any member of the community, 24 hours a day, seven days a week. Each Area Mental Health and Wellbeing Service will collaboratively decide on the best service configuration to deliver age-appropriate crisis responses across the 24-hour cycle.

In most areas, adult and older adult services may provide whole-of-life crisis responses with clinicians and support workers drawn from infant, child, youth and adult specialties as needed. In areas where there is enough demand, this may include dedicated infant, child and youth crisis responses (spanning 0–25 years) across the entire 24/7 cycle or for shorter periods around times of likely high demand. The Commission recognises that it is desirable to have crisis responses that are developmentally appropriate but that this might not always be feasible, especially in regional and rural areas. The Department of Health should monitor these arrangements and review them. If the demand for crisis responses for those aged 0–25 exceeds capacity, this may necessitate an increase in dedicated responses for infants, children and young people.

Core function 3: Support for primary and secondary care

Primary and secondary care and related services have a central role in the future service system and are where most infants and children will be seen and provided with treatment, care and support. To better support them, Infant, Child and Family Area Mental Health and Wellbeing Services will now provide primary consultation to infants and children being seen in this level of the system, secondary consultation to primary and secondary care and related services and shared care.

Support for primary and secondary care and related services is where area-level mental health clinicians 'reach in' and work directly with consumers, clinicians and support workers in these services.

Core activities generally include:

- giving second opinions on assessments and input into treatment plans and medication reviews (when the area-level clinician sees the infant or child in person, this is referred to as primary consultation; when this advice is provided via a discussion with the clinician or support worker it is referred to as secondary consultation)
- providing shared clinical care where the primary or secondary care clinician or support worker and the clinician or support worker from the area-level service deliver treatment, care and support together
- working directly with clinicians and support workers in primary and secondary care to build their capability—for example, through case review, observation, role-playing and behaviour modelling.

There are several existing models in Victoria (refer to case study on Bendigo child and adolescent mental health service for an example).

The benefits of this support include that more infants and children can be supported in these settings, avoiding the need for them to access Area Mental Health and Wellbeing Services. In addition to the benefits for the infant or child, this is an effective way for Area Mental Health and Wellbeing Services to direct their resources to those who need the highest intensity support. Further, support for primary and secondary and related services acts as a 'system glue' that promotes a system of treatment, care and support across primary, secondary and area-level services. In addition to capacity building, it develops referral pathways and builds relationships between clinicians. This assists with warm referrals and transfer of knowledge, and prevents consumers having to retell their story.

Clinicians and service providers spoke of the benefits of supporting primary and secondary care and related services. For example, Ziver Talat, Senior Social Worker at the Royal Children's Hospital's Child and Adolescent Mental Health Service's secondary consultation service, said that:

> It is about capacity building and probably getting a bit more bang for your buck. If we've … provided individual support to one student, we're probably not going to be as effective as if we had upskilled the teachers aid, the teacher and the wellbeing officer by going in and doing some secondary consultation and professional development. That will then mean that … teacher integration aid and wellbeing officer can provide that support to other students as well.[140]

Infant, Child and Family Area Mental Health and Wellbeing Services will develop models of support to deliver these new functions that are best suited to their local contexts. Priority should be given to working with:

- GPs, paediatricians and private psychologists and psychiatrists (where they are available)
- maternal and child health nurses
- wellbeing and support staff in primary schools and teachers
- child protection principal practitioners and practitioners from Child FIRST / The Orange Door
- clinicians and support workers in Take Two
- staff in Aboriginal community-controlled health organisations.

In addition to the new approaches to support primary and secondary mental health and related services, Infant, Child and Family Area Mental Health and Wellbeing Services will also now support enhanced maternal and child health nurses to help vulnerable families through a program of highly targeted assertive outreach.

In this new program, senior mental health clinicians from Infant, Child and Family Area Mental Health and Wellbeing Services will provide joint clinical care to a targeted number of families across the state alongside enhanced maternal and child health nurses in each local government area. The families who are most vulnerable to experiences of mental illness getting worse will be prioritised to receive treatment, care and support on the days the area-level clinician works alongside the enhanced maternal and child health nurse.

The existing enhanced maternal and child health nurse program is an assertive outreach program that responds to the needs of children, mothers and families who are at risk of poor outcomes and provides a more intensive level of support in the form of targeted actions and interventions.[141] The enhanced maternal and child health nurse program is available across the state and is estimated to support up to 15 per cent of Victorian families with children from birth to three years of age.[142]

Enhanced maternal and child health nurses have established connections with families that have already been identified as requiring support, including for mental health and wellbeing challenges. A 2019 study that surveyed the enhanced maternal and child health nurse program in all 79 local government areas found that the most common reasons for referral into the program were mental health (25 per cent of all referrals), family violence (20 per cent of all referrals) and drug and/or alcohol issues (14 per cent of all referrals).[143] An enhanced maternal and child health nurse coordinator in the study indicated:

> **The initial referral may be for sleep settling but when the home visit is conducted there is disclosure of relationship difficulties and family violence or drug/alcohol use, or mental health etc.**[144]

Joint assertive outreach between these two parts of the infant, child and family mental health service stream provides a unique opportunity for earlier intervention and to increase the support available to vulnerable families. Eastern Health's child and adolescent mental health service already delivers a similar program (refer to case study on Eastern Health's Infancy Access Project). Lessons from this program should be harnessed in developing this new function across the state.

The expansion and reforms of the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services are substantial and will require change at many levels. This includes at the structural, system, service, individual and cultural levels. Because the reforms have been guided by the voices of families, system leaders and clinicians, the strong support required to take these reforms forward already exists and should be harnessed.

Some of the reforms in this chapter rely on implementing the Commission's broader reform agenda, such as establishing the Regional Mental Health and Wellbeing Boards and the various legislative changes required. The availability of the right funding, workforce (including training and entry-level positions) and infrastructure is also an important implementation factor.

As discussed in more detail in Chapter 37: *Implementation*, the implementation of the Commission's reform agenda will be staged over a 10-year timeframe, with three waves of reform (short, medium and long term).

For these reforms to implement the new infant, child and family mental health and wellbeing service stream, most will be fully implemented within the short-term wave.

Case study:

Bendigo Child and Adolescent Mental Health Service

In addition to its daily provision of services, Bendigo Health's child and adolescent mental health service participates in a fortnightly clinic, run in partnership with local paediatricians to treat and care for children aged 0–12 years who have been referred with significant mental health difficulties.

Dr Liam O'Connor, Child and Adolescent Psychiatrist at Bendigo Child and Adolescent Mental Health Services, said the clinic has been running for four years and was set up as a means of bringing child psychiatrists, child and adolescent mental health service clinicians and local paediatricians together.

> Many children with behavioural and emotional difficulties are seen initially by paediatricians—and so the interaction between psychiatrists, mental health clinicians and paediatricians is incredibly important. It is vital to explore ways of working together, discussing complex cases and increasing mutual understanding.

Dr O'Connor said the focus of the fortnightly clinic is on children with complex issues, usually a combination of physical and mental health concerns. Once a month a paediatrician and child psychiatrist meet with child and adolescent mental health services clinicians for case discussion.

> In [the child and adolescent mental health services], we try to work out how best to manage each referral when it comes in—those selected for the clinic are usually ones where there is a mixture of physical and mental health issues.

Dr O'Connor noted that the clinic includes a paediatrician and a child and adolescent mental health services child psychiatrist.

> The two specialists conduct the assessment with the child and family together. While the majority of work involves initial assessment of newly referred children the clinic also offers secondary consultation with ongoing [child and adolescent mental health services] cases.
>
> Having both a paediatrician and a child psychiatrist in the same room is a valuable experience for young people and their families.

Dr O'Connor said the clinic was developed to deliver better services for the region.

> We need to be inventive to best meet the mental health needs of children in our region. The clinic is a Bendigo initiative based on local resources and need. It is one of a number of ways in which paediatricians and [child and adolescent mental health services] clinicians meet together to increase mutual understanding and quality of care.

In addition to the fortnightly clinic, child and adolescent mental health services staff meet with paediatricians for liaison and coordination between lead clinicians, psychiatrists and paediatric staff (paediatricians, registrars and allied health) for individual children and young people. There is also a six-weekly liaison meeting for case discussion and education.

Bendigo child and adolescent mental health service clinicians also attend care team meetings with paediatric inpatient ward staff, support development of safety plans and provide professional development and information sessions as needed.

Source: RCVMHS, *Interview with Dr Liam O'Connor*, October 2020; Bendigo Health, 'Child and Adolescent Mental Health Service (CAMHS)' <bendigohealth.org.au/ChildandAdolescentMentalHealthService>, [accessed 14 October 2020].

Case study:

Infancy Access Project

Eastern Health's Infancy Access Project aims to support improved early intervention with families who would benefit from targeted support. It was developed in recognition of the under-representation of children under four years of age within child and youth mental health services. Initially started in 2017 as a partnership between Eastern Health's Child and Youth Mental Health Service and Maroondah Maternal Child Health Services, it has now expanded to two more local government areas: Whitehorse and Yarra Ranges.

Ms Lynne Allison, Associate Program Director at Eastern Health Child and Youth Mental Health Service, said the child and youth mental health service was aware that it was perceived as prioritising adolescents due to this cohort's often acute mental health challenges and not necessarily giving appropriate weight to the complex developmental risk factors that younger children and infants present with.

> Consequently, we sought to make our service more flexible and accessible for the younger age group, bearing in mind the importance of early intervention.

The Infancy Access Project co-locates senior mental health clinicians with local enhanced maternal child health services to provide mental health assessments in the family home alongside the enhanced maternal child health nurse. Ms Allison noted one of the benefits of working with maternal child health services is that they have broad reach and are trusted in the community.

> Every family that has a newborn baby is connected to Maternal Child Health. It is a very safe space to engage, it is non stigmatising, it is local, and they have an engagement with a family for several years, possibly longer because of subsequent children.

Ms Amity McSwan, Team Leader of the Specialist Child Team 0–12 at Eastern Health's Child and Youth Mental Health Service, and one of the clinicians working in the project, said that the ability to meet with families in their own home alongside the enhanced maternal child health nurse provides a more casual setting in which the family is more relaxed and the family dynamics and needs can be more easily understood. It builds on the established relationship between the family and the enhanced maternal child health nurse.

> The nurse might be assessing the baby while we're all having a chat. It's a pathway to siblings as well as to the baby. We see the whole context of the family and the difficulties they are experiencing.

Ms Allison explained that the project can also reduce parents' fear of accessing child and youth mental health services because it is not in a clinical office setting where parents can sometimes feel there is something seriously wrong with their child.

> By locating the service in the safe space of maternal and child health, some of the fear and stigma is removed and many of these concerns can be quickly allayed directly.

Ms McSwan said the project has helped build the capacity of both maternal child health and child and youth mental health service staff.

> Initially, we ran professional development for the nurses, not just the Enhanced Maternal Child Health nurses, but all of the Maternal Child Health nurses. Most of the learning for me has been on the ground working alongside the Enhanced Maternal Child Health/Maternal Child Health nurse, and I know they would say the same, in terms of what we are looking for and how we engage with families.
>
> Because we have had more referrals of infants coming through this Project, it has improved clinicians' capacity to understand and effectively work with younger children and their families.

Ms Louise Dockery, an enhanced maternal child health nurse who works with the project through Maroondah Maternal Child Health Services, said the program has led to significant sharing of knowledge and resources.

> The [enhanced maternal child health nurse] is an outreach service to those families experiencing vulnerability, and endeavours to forge a positive and trusting relationship with families. The establishment of a positive relationship with families has resulted in the acceptance of a referral to and an in-home assessment with the [child and youth mental health services] clinician. Families meeting with a [child and youth mental health services] clinician in their home has proved highly beneficial and resulted in high engagement with the service.
>
> The relationship between the [enhanced maternal child health nurse] and [child and youth mental health services] clinician is respectful and supportive and is key to the success of the program.

Ms Allison said that over the first 12 months of the project, it increased referrals in the 0–4 age range by 30 per cent. An external evaluation is underway to understand the program's broader benefits. Ms Allison said Eastern Health hopes to expand the project to the remaining local government areas in its catchment in the future.

Source: RCVMHS, *Interview with Lynne Allison and Amity McSwan*, October 2020; Eastern Health, Submission to the *RCVMHS: SUB.0002.0028.0585, 2019*; Amity McSwan, *Correspondence to the RCVMHS*, 2020

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Chapter 13

Supporting the mental health and wellbeing of young people

Recommendation 20:

Supporting the mental health and wellbeing of young people

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, establish a dedicated service stream for young people, consisting of Youth Area Mental Health and Wellbeing Services, within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(c)) to:
    - **a.** appropriately adapt and deliver the core functions of community mental health and wellbeing services set out in recommendation 5, including through a range of delivery modes and ensuring services are accessible and responsive to the diversity of local communities; and
    - **b.** provide both short-term and ongoing treatment, care and support to young people, including those who require ongoing intensive treatment, care and support.
2. ensure Youth Area Mental Health and Wellbeing Services are available for young people aged 12 to 25 (until a person's 26th birthday), with age boundaries and transitions to be applied flexibly by services in partnership with young people and their families, carers and supporters.
3. support the development of formal partnerships, step-up and step-down referral pathways, shared staff and infrastructure and co-location between headspace centres and Infant, Child and Youth Area Mental Health and Wellbeing Services.
4. work with the Commonwealth Government, headspace National and Primary Health Networks to ensure that Infant, Child and Youth Area Mental Health and Wellbeing Services become the preferred providers of headspace centres where they exist or are established in Victoria.

Recommendation 21:

Redesigning bed-based services for young people

The Royal Commission recommends that the Victorian Government:

1. review, reform and implement new models of multidisciplinary care for bed-based services for young people that are delivered in a range of settings, including in young people's homes and in fit-for-purpose community and hospital environments.
2. deliver a broad range of bed-based services, including as a matter of immediate priority:
   a. ensuring every region has a Youth Prevention and Recovery Centre for young people aged 16 to 25, supported through a common and consistent model of care;
   b. creating a new stream of inpatient beds across Victoria for young people aged 18 to 25 by reconfiguring existing inpatient beds for adults and using an allocation of the 100 new beds referred to in recommendation 11(3); and
   c. ensuring Hospital in the Home services are available for young people as an alternative to acute hospital-based treatment, care and support where appropriate.
3. formally review the Youth Residential Rehabilitation Program, in consultation with young people, as well as families, carers and supporters.

13.1 A new youth mental health and wellbeing service stream

It is vital that Victoria has a strong, fit-for-purpose youth mental health and wellbeing service stream. As noted in the *Global Framework for Youth Mental Health*, the new youth mental health and wellbeing service stream must harness the benefits of early intervention–welcoming young people in as soon as challenges arise:

> Targeting preventive measures and effective early intervention at young people presents the best opportunity to reduce the social and economic costs of mental illness.[1]

Victoria is the home to many innovations in youth mental health and wellbeing. These include the early psychosis treatment model, single-session therapy and Youth Discovery Colleges. Victoria is also home to Orygen, the National Centre of Excellence in Youth Mental Health,[2] which is internationally recognised in translational research for young people.[3] Victoria also has a strong network of headspace centres, which provide holistic mental health and wellbeing care to young people.[4]

Despite these innovations, young people and their families, clinicians, service providers and academics, told the Commission that youth mental health and wellbeing needs to be better supported in Victoria's future mental health and wellbeing system. They indicated that substantial reform is needed to ensure Victoria's future youth mental health and wellbeing service stream can serve the needs of young people and support them to live a life that they value. One young person told the Commission:

> Instead of being told I'm the problem, it should be about helping me with whatever difficulties I'm having.[5]

Many young people shared how hard it can still be to ask for help. A mental health and wellbeing system that serves and supports young people needs to start by making this fundamental step easier. Mr Daniel Bolger, a witness before the Commission, said that:

> I didn't wanna seek any treatment because, as a guy, a 17-year-old guy who was at an all-boys school, played football, I just didn't want to associate myself with the label of having mental health issues. I was a strong dude, I felt like it was a weakness at that age.[6]

Young people shared that when they or their family, carers or supporters sought out help, it was difficult to find services, and some were told they were not sick enough to meet the threshold to receive help. Ms Amelia Morris, a witness before the Commission, shared how this felt for her:

> One of the main problems I encountered with the mental health system was that when I asked for help, it felt like there was nothing there. The narrative around mental health seems to repeat the same message – "don't be afraid to ask for help". The problem comes when you ask, there doesn't appear to be any answer.[7]

Associate Professor Alessandra Radovini, Director of Mindful at the University of Melbourne and Consultant Psychiatrist at Orygen, who gave evidence in a personal capacity, observed that:

> the entire system for adolescents and young people is underfunded and compounded by a maldistribution of resources not only across the state but also in different parts of metropolitan Melbourne. This significant unmet need has the effect that young people 'fall between the cracks' between primary and tertiary care, or more recently between generic and specialist care—this is referred to as the 'missing middle'.[8]

Some young people who did receive help spoke of uncompassionate responses, treatment cycles being cut short to make room for others and adult models of care being applied. Some also described having to go to multiple service providers to receive the treatment, care and support they need.

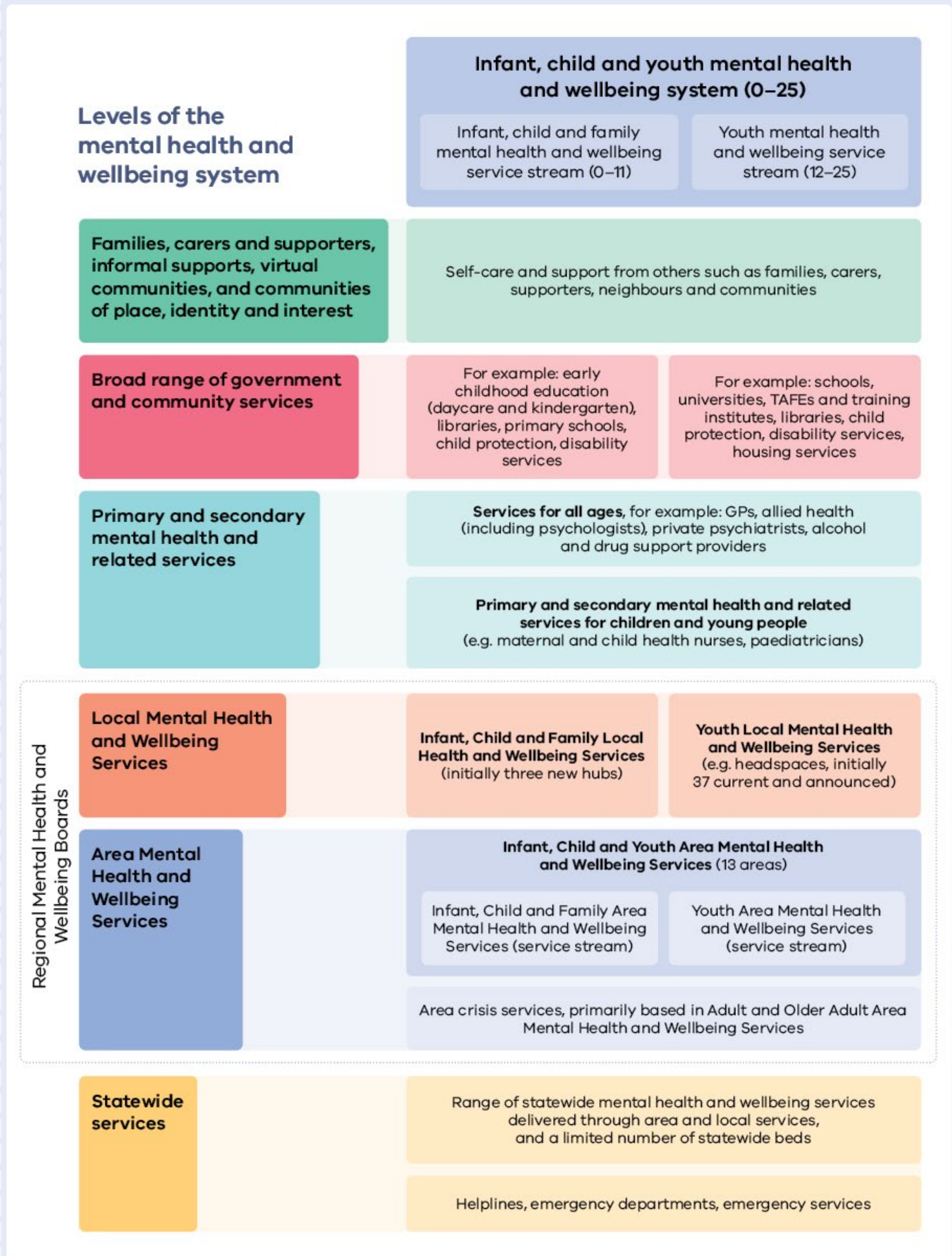
The need for a reformed approach to youth mental health and wellbeing in Victoria is clear.

13.1.1 Overview of the new youth mental health and wellbeing service stream

This chapter outlines the design of a new 'youth mental health and wellbeing service stream' for young people aged 12–25 years. As outlined in Chapter 5: *A responsive and integrated system*, the reformed mental health and wellbeing system will introduce two parallel but connected systems. One of these systems will be for infants, children and young people aged 0–25 years old. This system will have two distinct streams of service, one for infants, children and their families (from birth to 11 years old), and the other for young people (aged 12–25 years old). Within this service stream, young people will have access to different levels of treatment, care and support depending on the intensity of their needs. Major reforms will see services delivered through **Youth Local Mental Health and Wellbeing Services**, and **Infant, Child and Youth Area Mental Health and Wellbeing Services**. Within the Infant, Child and Youth Area Mental Health and Wellbeing Services there will be a distinct service stream for young people, called **Youth Area Mental Health and Wellbeing Services**. Figure 13.1 provides an overview of the new system and service structure for youth mental health and wellbeing.

The premise of the youth mental health and wellbeing service stream, as depicted in the right-hand column of Figure 13.1, is that the first levels support the greatest number of young people. At each subsequent level, the number of young people requiring support is fewer and fewer. Conversely, the specialisation of clinicians and support workers is highest in the lower levels, so the intensity of treatment, care and support is proportionate to a young person's situation, complexity and needs.

Figure 13.1: An overview of the future mental health and wellbeing system—infant, child and youth



Note: Developmentally appropriate transitions will be applied between age-based systems and service streams.

The initial levels of the service stream are the broadest. They are also the closest to home. This recognises the central role that families, carers and supporters play in mental health and wellbeing. There is also a wide range of organisations and resources that promote good mental health and wellbeing at these initial levels. These include online resources, youth groups, sporting clubs, self-help apps, websites and online communities.

At the next level are a broad range of government and community services. These are generally outside of the mental health and wellbeing system but have a responsibility to help young people live well. For young people, they include secondary schools, universities and TAFEs—many of which have embedded mental health clinicians and support staff available to help young people in the places where they learn.

Primary and secondary mental health and related services refer to the central role that GPs, paediatricians, private psychologists and psychiatrists, and youth alcohol and other drug workers play in providing young people with mental health treatment, care and support.

The remaining three levels in Figure 13.1 comprise the mental health and wellbeing services that will support young people with more complex or intensive support needs. Young people who need this level of support need specialised multidisciplinary treatment, care and support from clinicians and support workers from several disciplines coming together. The team forming around the young person may include, for example, a peer worker, psychologist, social worker, wellbeing support worker, occupational therapist and a psychiatrist. Staff from other agencies, such as child protection, family violence and disability services, may also need to join the team from time to time.

The role of **Youth Local Mental Health and Wellbeing Services** in the youth mental health and wellbeing service stream will be predominantly played by the network of headspaces across Victoria, although, over time, other providers may also choose to become providers of Youth Local Mental Health and Wellbeing Services. There are 26 headspace centres in Victoria, with another 11 scheduled to open.[9] The Commission recognises that the headspace model continues to mature towards its full vision and aspiration and that the breadth, coverage and effectiveness of headspace centres across Victoria varies.[10]

For example, some headspace centres are already fully integrated with area mental health services, and others operate more akin to 'enhanced primary care'.[11] The Commission envisages that in the future system, all Youth Local Mental Health and Wellbeing Services, including headspaces, will be better integrated with Infant, Child and Youth Area Mental Health and Wellbeing Services.

As outlined in Chapter 5: *A responsive and integrated system*, **Infant, Child and Youth Area Mental Health and Wellbeing Services** will be delivered through a partnership between a public health service or public hospital and a non-government organisation that provides wellbeing supports.

There will be 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (replacing the current child and adolescent mental health services and child and youth mental health services), across the eight regions proposed by the Commission. These will be the entities that are commissioned to deliver services. Within each will be the service stream of **Youth Area Mental Health and Wellbeing Services** for 12–25-year-olds. These service streams are not separate entities. The Commission recognises that the language of 'service streams' is technical, but has deliberately used it to be clear about governance.

Youth Local Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services will be formally networked within each of the eight regions. They will work together in partnerships to provide treatment, care and support to young people with the most complex support needs. In the future system, young people might simultaneously use both services to get the treatment, care and support they need.

Most young people will receive treatment, care and support through a range of government and community services and primary and secondary mental health and related services. As such, funding will be provided for specialist mental health clinicians and support workers from the Youth Area Mental Health and Wellbeing Services to 'reach into' primary and secondary mental health and related services. They will work alongside clinicians and staff in these organisations to build their capability and provide formalised shared care.

While the youth mental health and wellbeing service stream will be anchored in services that are delivered in communities, it will be complemented by treatment, care and support provided in hospital and community bed-based services; for the rarer occasions when young people need help that is best provided in a bed-based service. The Commission's reforms will increase the range of bed-based services available to young people, and the safety and appropriateness of those services. This reform will introduce a new youth acute inpatient stream for young people aged 18—25 years so they are no longer admitted to adult acute inpatient wards.

Chapter 5 also outlines proposed isolated arrangements for the Royal Children's Hospital to deliver community-based mental health and wellbeing services to children up to the age of 12 years, and Orygen to deliver youth mental health and wellbeing services for young people aged between 12 and 25 years. The Royal Children's Hospital will continue to deliver acute inpatient care to young people aged 13–18 years through its existing Banksia ward, which has a statewide role, admitting young people from across Victoria. Chapter 5 also describes the Commission view that Orygen's clinical services should be separated from Melbourne Health.

To establish the youth mental health and wellbeing service stream will require an ambitious program of reform. While implementation must start immediately, reform of this scale is only likely to be fully realised over multiple years. It will require support from the Commonwealth Government and Primary Health Networks, whose actions must be aligned with the reforms. Importantly, these reforms must be implemented through co-design with young people and their families, carers and supporters.

Once fully implemented, the new youth mental health and wellbeing service stream will be resourced and versatile enough to respond when a young person asks for help. The new service stream will have a culture of supporting every young person. It will draw on each young person's unique nature and acknowledge their resilience and strengths, allowing them to set their own goals and lead their recovery.

In a witness statement to the Commission, one young person confirmed how much young people need this change:

> I'm stuck in that relationship with the system. Moving away from a deficit way of thinking would change this relationship as you start to say okay, you're struggling with this because of X, Y, Z —how can we help? This change in mindset would make a huge difference.[12]

Personal story:

Natasha Swingler

Natasha (Tash) is 21 years old and has experienced mental health issues for over half of her life. She began self-harming at the age of 10, and at 17 years old was taken to hospital because she was suicidal. Following a period on a waiting list to access services, Tash worked with a clinician at a youth mental health service before being referred to a psychiatrist.

Despite taking medication, Tash deteriorated further and was admitted to a private inpatient unit for two months. Upon finishing school, Tash was referred to a tertiary youth mental health service where she was diagnosed with borderline personality disorder, depression and anxiety with psychotic features, and was experiencing substance abuse. Tash was admitted multiple times to various public and private units and had a number of interactions with emergency services.

Tash received good results from school and has gone on to study at university. Tash said that 'being 'high functioning' can be a curse as to many people I speak rationally and can perform tasks, which leads them to conclude my distress isn't that great'. This means she does not always receive the care she feels that she needs. Tash would like to see distress recognised in the same way as function.

> **I have experienced and witnessed that mental health services and clinicians often assess your wellness based on your ability to 'function'. If you function, then you can't be unwell, when in many cases being busy is a trauma-response.**

Tash has since experienced a re-emergence of symptoms while at university and has transitioned into adult mental health services due to time limits on access to some youth mental health services. Tash said, 'the strict time limits … are not helpful for young people, and risk breaking good relationships with services and placing young people inappropriately into adult services'.

The adult mental health services team was hesitant to support Tash, but agreed to treat her after speaking with the clinical psychologist. Tash did not have access to private supports at this time as no one in the private sector was willing to treat her due to risk and complexity. Tash feels pressure to be discharged by the adult clinic and said 'at times their practice is not as good as youth services but I realise that all services work and deliver their care differently'.

Since then, Tash voluntarily went to a Prevention and Recovery Care (PARC) centre for support following heightened suicidal ideation and self-harming. While her experience there was positive, she was 'clearly the youngest by at least 20 years'. Tash describes the challenges of being a younger person in an adult service:

> It's disheartening when you are surrounded by adults who are critically unwell—you question whether that's what your future will hold. Will I always be so unwell? Will I ever amount to anything?

Tash says her experiences have highlighted varied approaches to care and limited support for young people in the adult system. She would like to see better transitions between youth and adult services and a young adult mental health service that 'specifically targets the needs of young people who are legally adults however have varying mental health needs'.

Tash also spoke about the additional challenges the COVID-19 pandemic has brought for her wellbeing and ongoing care. During this time, she has experienced uncertainty in employment, complications regarding safety in the workplace and has felt there has been a 'disinterest in protecting young people in certain industries'.

> My hours at work were reduced, and I was forced to take annual leave (which I was lucky to have as a part time worker). Working in fast food puts me in close contact with hundreds of customers, and then I go home to my parents, who are of an age vulnerable to COVID-19 and its complications. This is not a fear I can easily put aside. We have already had one confirmed case in my store, after which I was tested and isolated.

Tash said the heightened exposure to COVID-19 and 'waking up to new information regarding work closures and COVID-19 related impacts day after day' has affected her mental wellbeing.

> I began to see panic attacks re-emerge and increase to a point where they were a daily experience.

Currently, Tash's usual supports and treatment are either reduced or accessed remotely.

> At the moment, I am receiving care primarily via phone or telehealth. It is difficult to have safe appointments over the phone as I don't feel comfortable speaking about my wellbeing or challenges I face whilst at home.

In addition, Tash was recently assigned a new clinician at her public mental health service. Tash said she has found this difficult when only being able to meet virtually.

> Changing to a new clinician who I had never met in person and would not be able to meet in person for a significant time period exacerbated my paranoia, my fears regarding potential use of treatment orders, alongside concerns about how I would engage with this new person.
>
> The restrictions on being able to see my clinician in person have meant that our relationship has not yet developed to a point where we talk openly and comfortably about some of my most challenging topics, including disordered eating, self-harm and suicidal ideation.

Tash said that while she feels somewhat supported, 'I often feel stuck, as though I cannot continue to recover in this environment, but I do not want to go backwards either.' With reduced access to her psychiatrist and vocational worker, she has not been able to change medications, as planned before COVID-19, or find employment she finds more consistent and meaningful.

While she has struggled with the impacts of COVID-19, Tash is happy to see the additional attention paid to mental health and the additional Medicare sessions and hopes workplaces will continue many of the changes that have allowed people to work from home.

Source: RCVMHS, *Interview with Natasha Swingler*, August 2020; Natasha Swingler, *Correspondence to the RCVMHS*, 2020; *Personal Story of Natasha Swingler, Collected by Victoria Legal Aid.*

13.1.2 Overview of the features of the new youth mental health and wellbeing service stream

In designing the future service stream, it was important to understand the perspectives and preferences of young people regarding youth mental health and wellbeing services. Many young people contributed to the Commission's work. These contributions included individual, group and organisational submissions, attendance at consultations and hearings, and participation in workshops and roundtables. A 2020 headspace survey of 1,345 young people summarises what young people value the most when engaging with services:

- knowing they won't be turned away (92 per cent)
- a welcoming and safe space (91 per cent)
- free or low cost (90 per cent)
- knowing the service is youth friendly (87 per cent)
- easy to get to (84 per cent)
- being able to be connected to other services if needed (84 per cent)
- having all their needs met in one location (83 per cent).[13]

The Commission listened to youth mental health clinicians, academics and advocacy groups about what they had learnt in delivering mental health and wellbeing services to young people.

The Commission also reviewed the evidence regarding effective youth mental health and wellbeing services internationally, noting that, as well as the establishment of headspace in Australia, in recent years there has also been growth in dedicated youth mental health services in other countries, including in Ireland and the United Kingdom.[14] This included reviewing Orygen and the World Economic Forum's *Global Youth Mental Health Framework*. Collectively, these reflections have underpinned the future service stream described in this chapter.

The first element is recognising that it can take courage for a young person to ask for help. For a range of reasons, including the stigma that is still associated with poor mental health, needing to ask for help and the fear of not receiving help, it can be hard for young people to seek help. Mr Jason Trethowan, CEO, headspace, spoke about the importance of welcoming young people into services:

> We make great efforts to ensure that each headspace centre is welcoming; the moment when a young person walks in the door is an important one. It is also an important opportunity to demonstrate to that young person that there is a place for them in the mental health system.[15]

Professor Patrick McGorry AO, Professor of Youth Mental Health, The University of Melbourne and Executive Director of Orygen, also spoke to the importance of removing barriers to entry and creating 'soft entry' points into the service stream to make it easier for young people to seek help.[16]

In the future service stream, there will be more youth friendly ways to seek help, including in education settings and from peer workers. Accessibility will be increased because services will be more flexible in when and how they are available to help. Across the service stream, there will be a strong and consistent culture of 'how can we help?', rather than 'how can we refer you on?' or 'are you eligible?' Help will also be made available as early as possible, rather than only when a young person's mental health and wellbeing challenges are clear enough to be diagnosed as a mental illness.

Another important element is increasing the number of young people who can be helped in the places where they live, learn and work. Headspace centres will continue to be a key part of the youth mental health and wellbeing service stream, and the Victorian Government will work with the Commonwealth Government to agree on strategies for better integrating headspace centres with higher intensity services in their areas. Young people will also continue to get support through secondary schools, TAFEs and universities. Through primary and secondary consultation and shared care, clinicians and staff from Youth Area Mental Health and Wellbeing Services will better support primary and secondary providers, including GPs and headspaces, to work with greater numbers of young people with higher intensity and more complex needs than has previously been possible.

Treatment, care and support will be developmentally appropriate and delivered in the relational context of the young person's life. Approaches will recognise the different ways in which young people choose and want to live their lives, their level of independence and the stage of life they are in—be it at secondary school, in higher education or in the workforce. Important aspects of the young person's life, such as employment, education, relationships and independent living, will be important considerations in assessing support needs. Their experiences, diversity and uniqueness will also be considered when deciding how best to provide help.

Youth peer workers will be a fundamental part of the workforce in Youth Area Mental Health and Wellbeing Services. Fully integrated and valued as equal members of multidisciplinary teams, youth peer workers will play a valuable role in orienting young people to services, providing navigational and emotional support, and coordinating their treatment, care and support. Services will need to consider how they can better use youth peer workers. Expansion of the scope of their roles is anticipated, including into care coordination.

The Commission also heard about the value of youth workers, particularly in relation to the delivery of wellbeing supports and in regional and rural areas where there can often be workforce shortages. Karina Kerr, Centre Manager for headspace Albury Wodonga, indicated that:

> workforce is a real important issue. If we're talking systemic change for the mental health service sector, we need to be able to diversify our workforce ... So the introduction of youth workers into the workforce [has been important], particularly with young people being able to have that connection, and not just focus on the dynamics of having a therapeutic intervention.[17]

The underlying approach of the youth mental health and wellbeing service stream is that young people are experts in their own experience and should be supported to make their own decisions, from the very first interaction with services. Services should support young people to articulate their strengths, and to determine their recovery goals, and should encourage them to feel positive about their recovery and future. While some services already do this well, some young people and their families indicated that this is not standard practice.

Ms Nicole Juniper, a witness before the Commission, said:

> **Young people need to be at the centre of their own care and treatment. They may not always be the ones that have to make a decision but they should be involved. I don't fully understand the decisions that were made around my care growing up, either because I wasn't told or I don't remember. Being part of the decision-making would have helped me to understand my own care so I could care for myself.**[18]

Specialist youth forensic services are also part of the future youth mental health and wellbeing service stream. Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*, recommends an expansion of specialist youth forensic services and their integration into Infant, Child and Youth Area Mental Health and Wellbeing Services. It also acknowledges that Orygen currently plays a lead role in the delivery of mental health and wellbeing treatment, care and support to young people who are involved in the youth justice system, or at risk of coming into contact with the youth justice system.

The future youth mental health and wellbeing service stream will benefit from the fact that Victoria is home to Orygen, Australia's largest mental health research entity. It focuses on early intervention and treatment for mental illness in young people.[19] Orygen's translational research capability spans discovery, novel treatment, clinical trials, service delivery, health economics and practice improvement research.[20]

As discussed in Chapter 36: *Research, innovation and system learning*, the Commission sees benefit in the Victorian Government identifying and promoting opportunities to increase collaboration in translational research and dissemination in relation to the mental health and wellbeing of infants, children and young people. Such opportunities can bring together people with lived experience, and a broad range of multidisciplinary experts and researchers to develop, translate and share best practice across the service stream.[21]

There are also opportunities to reduce the prevalence of mental health challenges among young people through increased primary prevention activity. As discussed in Chapter 4: *Working together to support good mental health and wellbeing,* the future approach to increase prevention activity for young people will involve government and non-government efforts to mobilise the many sectors outside of the mental health system that have strong potential to influence young people's mental health.

Through implementing the reforms outlined in this chapter, and a commitment by the Department of Health to keep working closely with young people, families, youth mental health clinicians, academics and advocacy groups, there is potential for Victoria's new youth mental health and wellbeing service stream to become world leading.

As outlined below, there are three fundamental features that underpin the future youth mental health and wellbeing service stream:

- developmentally appropriate transitions
- early intervention for young people
- involvement of families, carers and supporters.

Developmentally appropriate transitions

To make it easier to navigate the youth mental health and wellbeing service stream and improve continuity and quality of care as young people develop, the age of transition into adult and older adult mental health and wellbeing services will be made consistent across the state. Youth Area Mental Health and Wellbeing Services will provide treatment, care and support for young people aged 12–25 years (inclusive of the young person's 25th year). If young people need to transition into adult mental health and wellbeing services for further treatment, care and support, they will now do so consistently across the state on their 26th birthday.

This change will apply to treatment, care and support provided in the community, Prevention and Recovery Care units and acute inpatient services. Funding for services and programs for young people aged up to 26 years that are currently delivered by adult area mental health services will be transferred to the Infant, Child and Youth Area Mental Health and Wellbeing Services.

Where a young person's developmental and biological ages differ, or to allow the therapeutic benefit of treatment cycles already started to be finalised, services will have flexibility to determine the optimal transition age for individuals. They will do so in partnership with young people and their families.

While the youth mental health and wellbeing service stream is for young people aged 12–25 years, there are developmental differences within this age range. To ensure treatment, care and support is developmentally appropriate, and to ensure a degree of specialisation in the therapy provided, services will tailor their models of care to the age groups of 12–18-year-olds (encompassing adolescence and the secondary school years) and 18–25-year-olds (encompassing early adulthood and, typically, entry to higher education and the workforce).

Across the infant, child and youth mental health and wellbeing system, there will be shared clinical governance spanning the 0–25 year age group that will provide a safety net against disruptions in treatment, care and support for children who need to transition into the youth service stream. In Infant, Child and Youth Area Mental Health and Wellbeing Services, the service providers will be held accountable for smooth transitions and continuity of care.[22]

The reasons for lifting the age transition point into adult services are outlined below.

Young people, families, carers and supporters and clinicians, service providers and academics, spoke of the limitations of 18 being the age transition point into adult mental health services.

In a personal story collected by Victoria Legal Aid, one young person shared:

> In the youth services, there was a glimmer of hope that you would get better. But in the adult services, you're assumed to be unwell forever. The care was worse, and the staff didn't have the training to deal with someone that young. It happened with me and others. They don't know what to do to people that young. They throw you in an adult hospital, then they panic because they don't know what to do with you, and so they then want to discharge ASAP. I was just put in there and just ignored. It's as if I wasn't even there.[23]

Mr Kiba Reeves, a witness before the Commission, said:

> I have struggled dealing with the adult mental health system. In the paediatric system, they treat you like a kid and you have to be protected. The second you turn 18 you get treated like crap, like you are nuts, like you are a monster, like there is something seriously wrong with you. I felt the system was fine up until I came to the adult mental health system and then I felt I'm not worth anything because I'm an adult now. But I am not worth any less just because I am an adult. I may be 21 years old but most times I don't feel it. I am very much a child in my mindset. I still go to my dad for help, I still call my mum.[24]

One of the significant limitations is that a transition to adult mental health services at 18 often coincides with the onset of a range of mental illnesses, including psychosis. As noted below, one study suggests that as much as 50 per cent of mental illnesses occur before the age of 14 years and 75 per cent by 24 years.[25] Professor McGorry, spoke to the impacts of an age transition at 18 years, being ill aligned with the peak age for onset of mental illness:

> This structural divide between the specialist child and adolescent, and adult mental health services is a major problem, not only due to their differences in focus and therapeutic approach, but also because the discontinuity between service streams falls right within the age range where the incidence of new onsets peak, and the system is weakest where it should be strongest.[26]

Clinicians also spoke about the risks of the young person's care being disrupted or even stopped completely in the transition to adult mental health services as a result of the different eligibility criteria and models of care. Dr Neil Coventry, Victoria's Chief Psychiatrist, indicated that:

> Unlike [child and youth mental health services] where consumers with eating disorders and families are seen as core business, most adult area services do not treat consumers with eating disorders. As such, there is discontinuity in transition to adult services at age 18.[27]

Dr Coventry later went on to note that:

> young people receiving treatment for a specific condition, such as an eating disorder or a developmental disorder, may not meet the criteria for specialist adult services.[28]

Turning 18 can also be a vulnerable time for young people. It often coincides with major life transition points, such as finishing secondary school and entering the workforce, living independently and taking on more financial responsibility.

A more developmentally appropriate transition point to adult mental health services is 25 years (that, is on a young person's 26th birthday). The Royal Australian and New Zealand College of Psychiatrists stated that 'the shift in the age at which consumers transition to adult services to 25 ... has been associated with improved outcomes for many.'[29]

Research suggests the human brain continues to develop until a person is approximately 25 years old.[30] Brain development is a complex process. It appears to be influenced by a range of environmental, genetic and hormone differences, suggesting that until the brain is mature, young people are more vulnerable to environmental stress, risk-taking behaviours and behavioural challenges.[31]

Changes in society have also resulted in young people living with their families, carers or supporters for longer. Australian research in 2016 indicated that, at that time, 43 per cent of 20–24-year-olds lived with their parents compared with 36 per cent of 20–24-year-olds in 1981.[32] In this context, models of care that involve family, carers or supporters are critical. They are also more developmentally appropriate for most young people than the more individualised model of care typically used in the adult system. For example, Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Service and headspace, Alfred Health indicated that:

> it is preferable to transition patients to adult service at 25 rather than 18. I consider this to be a result of the children, adolescent and youth services involving families much more than the adult system.[33]

In Victoria, at the area level, child and youth mental health services currently provide community-based care spanning the age range of 0–25 years, and child and adolescent mental health services provide community-based care spanning the age range of 0–18 years. On this point, the Victorian Auditor-General's Office indicated that:

> There is a confusing mix of age eligibility arrangements across services—some treat young people up to the age of 25 and some up to 18. This is because in 2006, [the then Department of Health and Human Services] began increasing service eligibility to 25, but stopped the rollout midway through when the government changed.[34]

In the western and north-western regions of metropolitan Melbourne, Orygen Specialist Program provides community-based treatment, care and support to young people aged 15–25 years.[35] Monash Health has also created a dedicated youth service for young people aged 18–25 as part of its adult mental health service.[36]

Child and adolescent mental health services that have already transitioned to a service dedicated to people aged 0–25 years have indicated that this has been positive for young people. This includes Eastern Health Child and Adolescent Mental Health Service, which transitioned to 0–25 years in 2010. Ms Lynne Allison, Associate Program Director of Eastern Health's Child, Youth Mental Health Service, noted that:

> Internal evaluation of the model has been overwhelmingly positive – more young people have had access to specialist mental health than had previously been accepted within the adult mental health system due to their limited eligibility criteria, and clinical outcomes are also positive.[37]

Ms Allison did, however, indicate that a major limitation of the transition was that the former Department of Health and Human Services did not properly adjust relevant funding parameters to match the additional young people the service was now responsible for helping:

> Eastern Health received only 12% additional funding to service a 40% increased population.[38]

When implementing this reform, the Department of Health will need to ensure funding is provided proportionate to the increased responsibility of each Infant, Child and Youth Area Mental Health and Wellbeing Service.

This change in the age of transition to the adult and older adult mental health and wellbeing system means that Infant, Child and Youth Area Mental Health and Wellbeing Services may need to support some young people through earlier age-based transitions in other systems, such as graduation from secondary school.

Where there is not alignment in age transitions across sectors, the Department of Health will need to negotiate with other departments to ensure young people aged 18–25 are able to access their mental health treatment, care and support from youth mental health and wellbeing services. For example, negotiations should occur with the Department of Justice and Community Safety to agree the approach to mental health and wellbeing services for young people aged 18–25 years who require forensic mental health services and are in contact with the adult justice system. Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*, outlines the future approach to youth forensic mental health services.

Early intervention for young people

Early intervention is an important concept in youth mental health and wellbeing. The Youth Support and Advocacy Service described early intervention as:

> strategies targeting people displaying the early or emerging signs and symptoms of developing mental health problems. This requires the early identification of young people at risk so that a timely and effective response can be made to either resolve the problem before it progresses and becomes entrenched or reduces the impact of the problem over time.[39]

Early intervention means that treatment, care and support is provided when behaviours or support needs first appear. This ensures support is not delayed until the behaviours or needs are clear or advanced enough for a diagnosis of mental illness.[40] Early intervention in youth mental health has strong support from clinicians, academics and youth advocacy groups. They regard it as extremely important. For example, the *Global Framework for Youth Mental Health* indicates that:

> Intervening in the early stages of illness changes the perception of mental illness and provides hope that recovery and management of illness are not only possible but to be expected.[41]

Research has also indicated that the first experience of psychological distress—or behaviour indicating possible mental illness—often occurs two to three years before a diagnosis is made.[42] Although first distress, behaviours or experiences and mental illness can sometimes occur simultaneously, there is evidence that often there is a significant window of opportunity to intervene early to change the course, severity and impact of mental illness.[43]

Early intervention approaches in youth mental health and wellbeing services began in the treatment of psychosis. The early intervention psychosis model, developed in 1992, has produced an array of evidence for timely and comprehensive intervention during the first episode of psychosis, and for up to five years post diagnosis, while providing wellbeing supports to the young person through the onset phase.[44] Since that time, the early intervention model for psychosis has been extended across a range of mental illnesses, including mood disorders, eating disorders, substance use or addiction, and personality disorders.[45]

Research that compared the outcomes of people with first episode psychosis who received early psychosis intervention services with people with first episode psychosis who did not, suggested that, over the two years that followed the intervention, the people that had received the intervention had:

- substantially lower rates of mortality
- lower rates of emergency department presentations.[46]

Other research suggests that a two-year early intervention program with people with first episode psychosis significantly reduced the suicide rate in the first three years of treatment, with a significant reduction continued to be observed over the 12-year research period.[47]

While it is accepted by many that early intervention improves outcomes across the early years of the onset of an illness and during and after the early intervention treatment period, how to sustain those improvements once early intervention services cease and the person returns to normal care, or no care at all, remains a research priority.[48] The Adult Psychiatry Imperative argues that there is not yet evidence suggesting the benefits of early intervention continue over the long term without good-quality ongoing treatment, care and support.[49]

The importance of ensuring people who were receiving time-limited early intervention services can access ongoing treatment, care and support that is of an equivalent quality is clear. Several studies suggest 'progress made during early intervention [for psychosis] might not be maintained because of the poor quality of care that patients receive once they enter the adult system'.[50]

The Commission considers that the positive outcomes achieved through early intervention approaches—even if only short to medium term in some instances—make a strong case for reformed youth mental health and wellbeing services delivering and refining early intervention approaches.

Further, early intervention approaches should not be mutually exclusive from the provision of ongoing treatment, care and support (in either the youth service stream or the adult and older adult system). Both early intervention and ongoing supports when needed are necessary components of the future mental health and wellbeing system.

As Ms Juniper indicated, 'it's important to get in early before bad things happen'.[51]

Involvement of families, carers and supporters

Many young people, especially in adolescence, are strongly connected to families, carers and supporters. Research conducted by headspace in 2020 indicated that 64 per cent of young people said that knowing their family can be involved in their care was important to them.[52] In consultations led by the Youth Affairs Council Victoria, young people consistently identified family as a 'significant source of support when dealing with mental health issues'.[53]

The Commission also heard directly from young people about the importance of families, carers and supporters being involved in their treatment, care and support. One young focus group participant said:

> I always wanted my mum to kind of be kept in the loop because I didn't understand stuff … And there was always resistance like she would have a hell of a time. Especially after I turned 18. She had a hell of a time trying to get any information on what was going on with me. Even when I said I want my mum involved, they went 'No'.[54]

A young person's stage of social and emotional development—and their circumstances—influences the role they want their family, carers and supporters to have in their treatment, care and support.[55] But the starting assumption should be that young people are open to including families, carers and supporters. As noted by Dr Denborough, '[i]t is vital that families and carers are welcomed into community care services and provided with support as soon as possible.'[56]

Young people also want their families, carers and supporters to be supported in their own right and to receive help so that they could fully understand the mental health challenges young people experience. Another young focus group participant told the Commission:

> they [parents] often get missed with the support. They don't receive any support … And they didn't know how to support me properly because of the education that they didn't [receive].[57]

Future youth mental health and wellbeing services will address this need through a greater focus on providing family therapy, which engages a young person's support network (however that may look) through a collaborative, strengths-based approach to helping the young person. Services should ensure that family therapy is offered as standard practice, alongside individual and group therapy.

As part of a suite of family therapies available, Youth Area Mental Health and Wellbeing Services will also now offer single-session therapy to families who would benefit from this model of therapy. The underlying approach to single-session therapy is that young people and their families can 'effect change after one therapeutic encounter, using their own resources, with brief support and assistance from therapists'.[58]

As shown in the case study below, '[single-session therapy] has been found to be an effective intervention for children, young people and their families presenting with a wide range of difficulties',[59] and has been found to be recovery orientated, person-led and to reduce waiting times to receive help.[60]

Case study:

Single-session family therapy

Single-session family therapy supports family inclusion in a consumer's treatment, care and support for mental health challenges. The process is time limited and generally includes initial phone contact between a clinician and consumer and/or the completion of a pre-session questionnaire, one face-to-face session and a follow-up phone call, which functions both as a clinical contact and a means to determine future treatment or referral options.

Single-session family therapy is increasingly practiced across a range of service settings. Its application is largely based on evidence that suggests a large proportion of people only attend one session of care, and the majority of those who do not attend a second session do so because they are satisfied with the service they received. In Victoria, single-session family therapy is used by a range of service providers such as headspace, the Bouverie Centre and area mental health services such as the Alfred Child and Youth Mental Health Service. Its format does not require extensive training for practitioners.

Research indicates that single-session family therapy can be effective for young people. Findings from one study, which recorded client self-reported outcomes four to five weeks following a session, suggested the therapy led to considerable improvements to a young person's wellbeing. Another study, which involved a meta-analysis of findings from 50 randomised controlled trials (over 10,000 young people in total), indicated that while there was large variation between studies, overall young people who received single-session interventions were 58 per cent more likely to 'fare better' than those who did not.

Involving the family through this process can facilitate greater understanding, beyond a technical understanding, of a consumer's mental health challenge. It helps family members to develop an empathic response and understand their role in a consumer's treatment, care and support, which is critical to creating a supportive environment in which a consumer can recover. It can also provide an opportunity to acknowledge the impact of the mental illness on all family members. Single-session family therapy can be a less daunting experience, for both consumers and family members, than more intensive ways of involving family in treatment.

Single-session family therapy can be appealing to consumers because the session is focused and often targeted at pre-determined concerns (for example, those identified through the pre-session contact). It provides the opportunity to respond to what the consumer and family feels is important, rather than what the clinician might otherwise make a priority.

Single-Session Family Consultation Clinic at the Alfred child and youth mental health service

The child and youth mental health service at the Alfred includes the client's whole family and/or their social network within its definition of 'client'. Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, Alfred Health, said it is vital that families and carers are welcomed into community care services and provided with support as soon as possible.

Dr Denborough also said that family-based treatment for young people who are suffering from a suicidal crisis can be particularly effective as it can directly mediate risk factors like isolation, disconnection and loss of meaningful engagement. He noted that the severity or complexity of consumers' mental health challenges did not appear to affect outcomes.

> The clients and their families all had challenges that had been deemed serious enough to meet the threshold for a tertiary mental health service and level of severity or complexity did not appear to be a factor related to successful outcome. The only exclusion criteria for this approach was if the family specifically requested for a diagnostic assessment such as for autism.

Alfred child and youth mental health service first introduced single-session therapy as a family-based intervention in 2006 and has since expanded to three teams of six to eight clinicians. Two hours and 15 minutes is allocated to the session. A pre-session questionnaire is mailed to families to prompt them to think about the issues the consumer and family want to address through the session, and a written summary is sent to families afterwards.

A 10-year review of the program at the Alfred has shown that for almost 70 per cent of families, one session is sufficient. Only 5 per cent attend more than one session, with the remaining 26 per cent being accepted for case management. Four to six weeks after the session, a therapist will call the family to see what changes have been made as a family and if more support is needed.

Source: Jeff Young, Pam Rycroft and Shane Weir, 'Chapter 7: Implementing Single Session Therapy: Practical Wisdoms from Down Under', in *Capturing the Moment. Single Session Therapy and Walk-In Services* (Crown House Publishing Limited, 2014); Liza Hopkins and others, 'Single Session Family Therapy in Youth Mental Health: Can It Help?', *Australasian Psychiatry*, 25.2 (2017), 108–111; Jessica L Schleider and John R Weisz, 'Little Treatments, Promising Effects? Meta-Analysis of Single-Session Interventions for Youth Psychiatric Problems', *Journal of the American Academy of Child and Adolescent Psychiatry*, 56.2 (2017); *Witness Statement of Paul Denborough*, 11 May 2020; *Witness Statement of Dr Brendan O'Hanlon*, 17 June 2020; Fry, D, *Alfred Child and Youth Mental Health Service Single Session Program Ten Year Review*; The Bouverie Centre, 'Single Session Family Consultation Practice Manual' <bouverie.org.au/support-for-services/single_session_family_consultation_practice_manual#Single%20Session%20Family%20Consultation:%20An%20overview> [accessed 30 September 2020]; Dr Paul Denborough, *Correspondence to the RCVMHS*, 2020.

Many of the aspects of single-session therapy, such as adopting the language used by each family and assisting the young person and their family to 'make sense' of what is happening, are aligned with the Commission's reforms in this chapter.[61] Research also suggests that young people and families that have had single-session therapy consistently rated the experience highly.[62]

While single-session therapy may not be suitable for all young people and families, carers and supporters (such as people with complex trauma histories), many young people are likely to benefit from its wider availability across the state.[63] It should not be used as a substitute for ongoing treatment, care and support for those who need ongoing supports.

Where it is helpful to a young person's recovery, families, carers and supporters will also be able to access therapy for themselves directly from Youth Area Mental Health and Wellbeing Services. This therapy will be anchored in strengthening relationships with the young person they support and care for. It will also help respond to any relational and contextual matters affecting the young person. Families, carers and supporters will also be able to take courses at the youth recovery colleges that focus on increasing mental health literacy and empowering recovery.

In addition, families, carers and supporters, including parents, carers, and any children and siblings of young people accessing services in the youth mental health and wellbeing service stream, will be able to access supports as outlined in Chapter 19: *Valuing and supporting families, carers and supporters*. Three specific reforms described in the following sections will embed the involvement of families, carers and supporters in future youth mental health and wellbeing services.

The first is employing family peer workers in adequate numbers in all Infant, Child and Youth Area Mental Health and Wellbeing Services. Working alongside youth peer workers, clinicians and support workers, family peer workers will have an important role in orientating families, carers and supporters to the service, understanding their needs and preferences and providing emotional support. Family peer workers will also coordinate the supports that families, carers and supporters need from the service and connect them with the new regional family and carer centres. The family and carer centres, which are detailed in Chapter 19: *Valuing and supporting families, carers and supporters*, will provide tailored information about supports and services available in the region. They will also work with families, carers and supporters to identify their needs and connect them to support that can best respond to those needs.

Family peer workers will form an important part of the multidisciplinary workforce in Youth Area Mental Health and Wellbeing Services and will be fully integrated into teams. Emphasising the importance of this integration to value that family peer workers can have, Dr Denborough argues that:

> the key to making a peer workforce utilised is for the clinical staff to understand that they're as effective as a therapist. I mean, I know it's a different type of thing, but it has been quite a difficult thing to actually implement. Often peer workers are seen as something on the side ... someone who might do a bit of hand holding or support, but in fact our experience has been that, you know, sometimes the peer workers are more helpful than clinicians in terms of actually clinically – I don't like to use the word clinically—but therapeutically because of their lived experience and their ability to share things that they've done, particularly with the family peer workers.[64]

The second reform is introducing group-based parenting supports within Youth Area Mental Health and Wellbeing Services. These will assist parents, families, carers and supporters to strengthen individual and family relationships which, in turn, helps support the young person's mental health challenges. Research suggests that young people's mental health is strengthened when parents, families, carers and supporters receive support to implement

warm and consistent parenting practices, especially during difficult periods. This support also helps parents, families, carers and supporters achieve and maintain their own good mental health.[65] Parenting supports will be available to all parents, families, carers and supporters on an opt-in basis. They will be organised around age groups to ensure sessions are developmentally appropriate.

The third reform is formalising family, carer and supporter participation in the advisory and governance structures of each service, such as through positions on board, family advisory councils and other formally recognised structures. While some services already have such structures in place, not all do.

At the service level, the Commission's recommendations in Chapter 28: *Commissioning for responsive services* include the introduction of new service standards and a new self-assessment tool that can be used to assess providers against the standards and to determine which providers to fund. The new service standards will improve service conduct, including through family, carer and supporter partnerships in the leadership, accountability and governance areas. Once fully established, the service standards will look for strong governance, a unifying vision and strategy, and a culture of family, carer and supporter involvement and partnering.

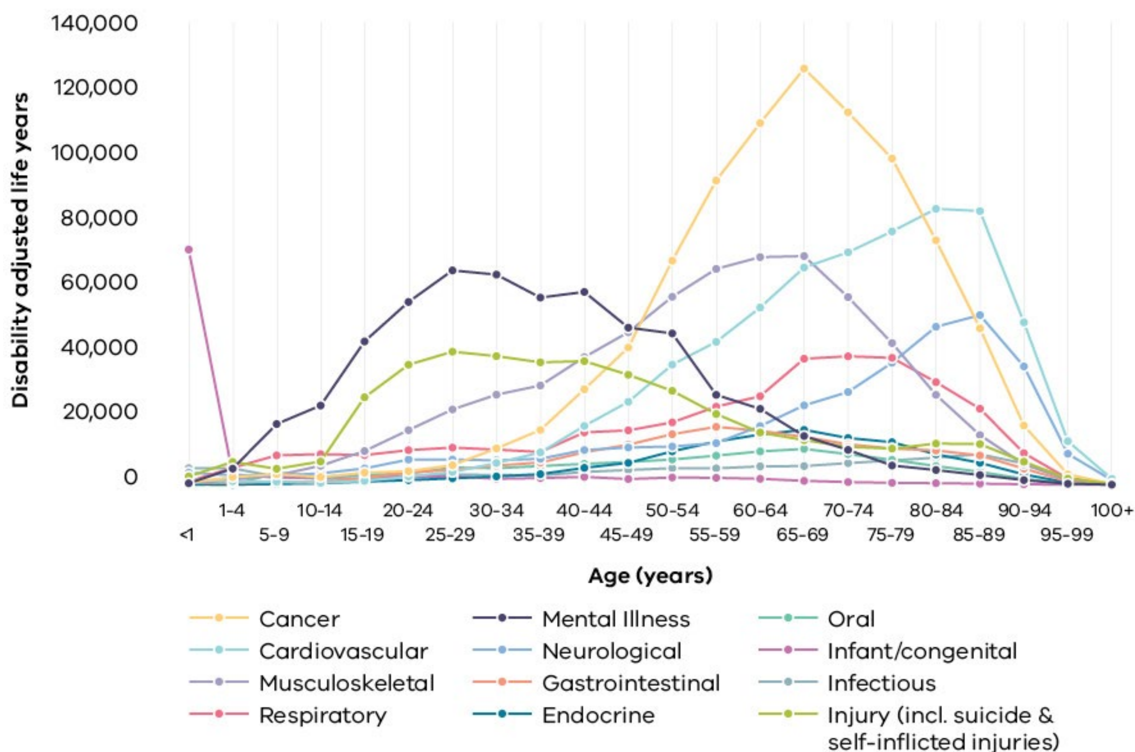
13.2 Mental health of young people

It is difficult to know, with certainty, the extent of the mental health and wellbeing challenges young people face. A range of factors contribute to this uncertainty. They include diverse understandings of what constitutes mental health and wellbeing, inconsistent and delayed data collection and reporting, and different definitions of young people.

The onset of many mental illnesses typically occurs in these formative years. A frequently cited study with more than 9,000 Americans aged over 18 years, conducted between 2001 and 2003, estimated that 50 per cent of mental illness has its onset before the age of 14 years and 75 per cent by 24 years.[66] Another study estimated that of a group of young people diagnosed with mental illness at the age of 26, 80 per cent had an earlier diagnosis from the age of 11 onwards, with 74 per cent having a diagnosis before 18 years old and half before the age of 15.[67]

This translates into mental health having a much younger age-based profile than other health conditions in terms of 'burden of disease,' as shown in Figure 13.2.

Figure 13.2: Australian burden of disease by disease group and age, 2015



Source: Calculation by the Commission based on the Australian Institute of Health and Welfare, Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015; Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW, National Estimates of Australia, 2019 data table. Table 2.A Total (5yrs).

Notes: Cancer includes cancer and other neoplasms; mental illness includes mental and substance use disorders; and injuries includes suicide and self inflicted injuries.

For further information see:
<www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/data>

Similarly, one study on the global 'burden of disease' suggested that mental illness is the leading cause of disability in young people aged 10–24 years, making up an estimated 45 per cent of the overall burden of disease.[68]

Recent Australian data in headspace's 2018 *National Youth Mental Health and Wellbeing Survey* examined the levels of psychological distress among more than 4,000 young Australians aged 12–25 years. The survey indicated that:

- nearly one in three (32 per cent) young Australians aged 12–25 years reported high or very high levels of psychological distress—more than three times the rate in 2007 (9 per cent)
- rates of psychological distress were significantly higher among young women (38 per cent compared with 26 per cent of young men)
- 18–21-year-olds reported the highest levels (38 per cent compared with 20 per cent of 12–14-year-olds)
- Victoria had the highest percentage of young people reporting high or very high levels of psychological distress—35 per cent compared to 33 per cent in Western Australia and South Australia, 31 per cent in New South Wales and 29 per cent in Queensland.[69]

Suicide also has a significant impact on young people. Data indicates that, sadly, in 2019 suicide was the leading cause of death among young Victorians aged 15–25 years.[70]

Young people have also indicated that mental health is a major area of interest and concern to them. Results from Mission Australia's *Youth Survey 2018* of 4,445 Victorians aged 15–19 years found that 72.9 per cent highly valued mental health, with 38.6 per cent indicating they were personally concerned about mental health and 14.3 per cent concerned about suicide.[71]

13.2.1 Onset of mental health challenges can occur at the same time as major development

Adolescence and young adulthood can be a difficult time for many. As Orygen, the National Centre of Excellence in Youth Mental Health, acknowledges:

> Adolescence and young adulthood is a period of great change, personal growth and an important time for a young person in terms of how they see and understand themselves, others and their place in the world.[72]

The onset for mental health challenges can occur at the same time young people are undergoing a major period of social and emotional development.[73] Education and employment pressures, growing social demands and early experiences of relationships are challenges most young people traverse as they transition into adulthood.[74] The transition from adolescence into the mid-20s can be a highly challenging period developmentally.[75] This includes a wide range of changes for the young person, including:

- physical (puberty and sexual development)
- psychological (increasing desire for autonomy, evolving identity as an individual, evolving values system and less reliance on family for emotional, social and economic support)

- cognitive (more complex thought)
- emotional (moving from being self-focused to empathising with others and seeing the bigger picture)
- social (identifying with peer groups and forming intimate relationships).[76]

The transition to adulthood is also where tobacco and alcohol can first be used legally. This transition period can also be a time of experimentation and risk-taking behaviour. The trajectory and outcomes of each young person's development are unique and are influenced by factors such as social determinants and resilience.[77] They are also mediated by a wide range of experiences, including stigma and discrimination related to sexuality and gender,[78] and relationships with their family, carers and supporters, including their parenting style.[79]

As noted by the Australian Medical Association (Victoria), it is imperative that treatment, care and support is delivered in the context of their developmental stage, strengths and challenges:

> Young people need a safe and therapeutic relational space to process both 'what has happened to them,' and 'what is happening now' in their lives, that overwhelms their abilities to cope effectively.[80]

Societal trends shape young people's development. Professor McGorry observed that young people today are faced with a much more challenging and less supportive environment than young people were 40–50 years ago.[81] With changes in the economy and to family dynamics, and widespread use of social media, giving evidence in a personal capacity, Professor McGorry noted that:

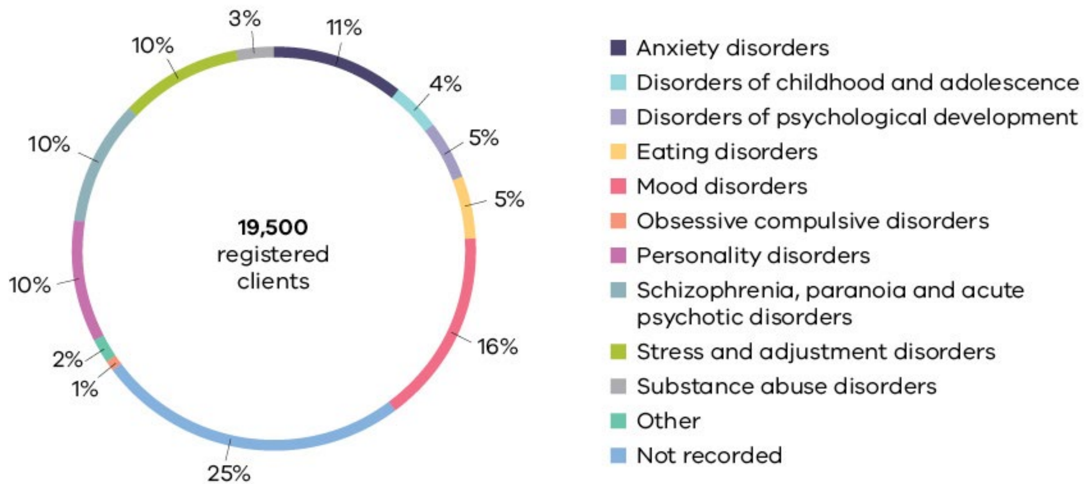
> Perhaps now there is more freedom and flexibility but much less support and scaffolding around young people as they mature and become independent. The scaffolding is fragile and can be blown apart, collapse or fall away very quickly, especially in the face of mental illness.[82]

Figure 13.3 shows the principal diagnosis trends of young people receiving treatment, care and support from child and adolescent mental health services or child and youth mental health services in 2019–20. These trends illustrate a much broader range of diagnoses than the equivalent trends for consumers aged 0–11 years.

13.2.2 The impact of COVID-19 on young people

In 2020, the devastating global COVID-19 pandemic arrived in Victoria, with consequences for the mental health, wellbeing and life circumstances of young people. Numerous public reports have been released on the current and projected impacts of COVID-19 on young people. These impacts include rising unemployment, unprecedented interruptions to education and social networks and impacts on mental health and wellbeing.[83] As the pandemic continues to evolve, research and data regarding its impact remains fluid.

Figure 13.3: People treated by the public specialist mental health system aged 12–25 years, by principal diagnosis groups, Victoria, 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

Notes: The International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) classifies diagnosis as follows: anxiety disorders include generalised anxiety disorders, social phobias, specific phobias and panic disorders; disorders of childhood and adolescence include attention deficit hyperactivity disorder and conduct disorder; disorders of psychological development include developmental language disorder, learning disorders and autism spectrum disorders; eating disorders include anorexia and bulimia nervosa; mood disorders include depressive and bipolar disorders; organic disorders include dementia, delirium, disorders due to medical conditions; personality disorders include dissocial personality disorder and borderline personality disorder; schizophrenia and other psychotic disorders include acute psychotic disorders and schizoaffective; stress and adjustment disorders include acute and/or severe stress, post-traumatic stress or adjustment disorders; substance abuse disorders include behaviour patterns associated with alcohol, cannabis, hallucinogens, inhalants, opioids, and stimulants; other includes disorders not classified elsewhere; and not recorded includes cases where diagnosis was not recorded due to collection error or the case did not warrant the allocation of a diagnosis.

For the purposes of this figure, other includes organic disorders and disorders not classified elsewhere.

Data excludes the Albury campus of Albury Wodonga Health.

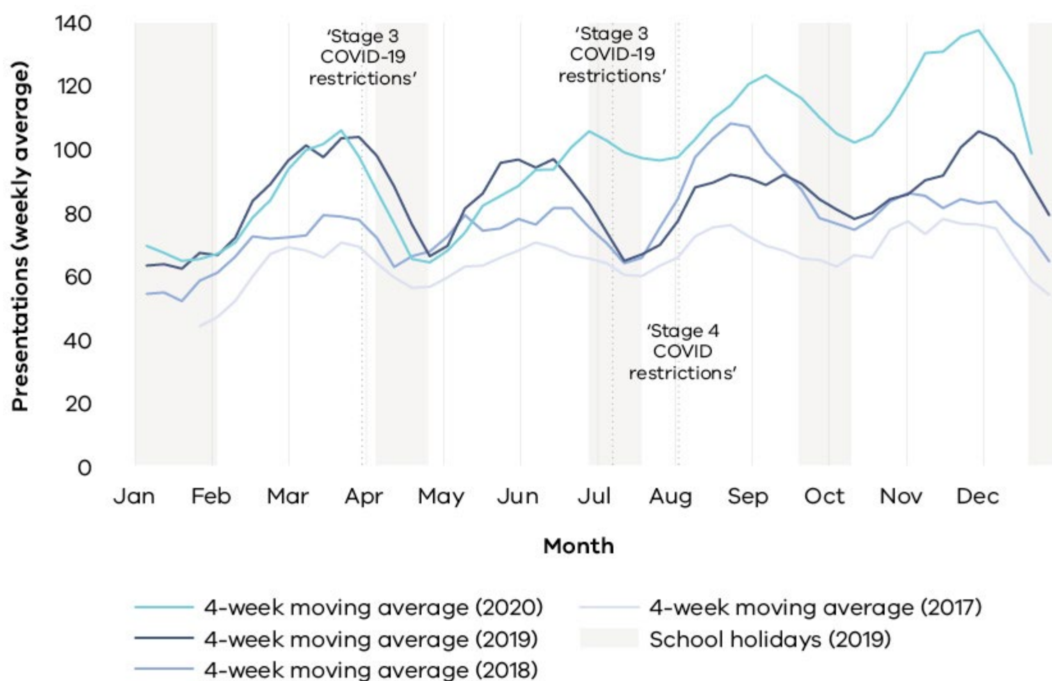
See Volume 5, Appendix B for additional information.

Over the peak period of the pandemic there were many helpful surveys and reports released regarding the impact of the pandemic on young people. One such report was from the Victorian Commission for Children and Young People, which published a report, *The Impact of COVID-19 on Children and Young People* on 7 September 2020. The report summarised the results of consultations conducted from April to July 2020 with 644 young people and 172 staff from 70 organisations that provide services and supports to children and young people.[84]

The report found that some children and young people were feeling 'unaffected or said there were some positive impacts associated with the restrictions, as they had the chance to slow down, self-reflect or avoid situations they find stressful'.[85] But most reported negative impacts, describing experiences of 'loneliness and isolation, disruption to routines and coping mechanisms, worry for loved ones and increased stress associated with remote learning, precarious employment or unstable housing'.[86] Some young people reported that the pandemic 'exacerbated their existing mental health issues, such as anxiety and depression'.[87] Others spoke about 'being affected by peer suicide in their communities during the pandemic or about being worried about their friends expressing suicidal thoughts'.[88]

As shown in Figure 13.4, emergency department data further reveals the impact of the COVID-19 pandemic on young people, with increases in the number of young people aged 0–17 years seeking help in connection with intentional self-harm and suicidal thoughts.

Figure 13.4: Number of intentional self-harm and suicidal ideation emergency department presentations, ages 0–17 years, Victoria, 2017–2020



Source: Department of Health and Human Services, Victorian Emergency Minimum Dataset 2016–17 to 2020–21.

Notes: Measure presents the moving average number of ED presentations per week with a recorded human intent code of '2', '18', '19', '20' (intentional self-harm), and/or those with a primary, secondary or tertiary diagnosis of 'R4581' (suicide attempt/ideation). Reported by departure date. Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival). Interim data only. Data extracted 7 September 2020.

Stage 3 COVID-19 restrictions: Was implemented on 30 March 2020 and again on 8 July 2020 for Metropolitan Melbourne, and allowed people to leave their home for only four reasons: work, caregiving or receiving, exercise and shopping for essential goods and services.

Stage 4 COVID-19 restrictions: Was implemented on 4 August 2020, and in addition to the restrictions under Stage 3, additional restrictions limited travel to up to 5 kilometres from a person's home for necessary goods and services. Only one person per household could leave home to shop once per day. Curfews were in place from 8:00 pm to 5:00 am every night to reduce the number of people leaving their homes and moving around.

Refer to Volume 5, Appendix B for additional information regarding COVID-19 restrictions in Victoria.

While the full impact of the COVID-19 pandemic will not be known for some time, the Department of Health must pay close attention to the immediate and longer-term impacts on young people's mental health and wellbeing. The expected increase in mental health and wellbeing challenges among young people as a result of the pandemic increases the need for urgent implementation of these reforms.

13.3 Reforms to redesign the youth mental health and wellbeing service stream

The reforms the Commission recommends are set out in more detail below. They build on the aspirations, concepts and elements already described in this chapter. The reforms concentrate on the most urgent and transformative opportunities—those that will make the most immediate difference to young people. They lay the foundations. Further innovation will be needed, especially as the impact of the COVID-19 pandemic is fully understood.

There are four overall reforms to delivering the reformed youth mental health and wellbeing service stream, each outlined below:

- support for schools (briefly discussed below, and in greater depth in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect)*
- strengthening Youth Local Mental Health and Wellbeing Services
- transforming Youth Area Mental Health and Wellbeing Services
- redesigning bed-based services for young people.

13.3.1 Support for schools

The Commission heard from many people about the valuable role of schools and higher education facilities. For example, the Productivity Commission's *Mental Health Inquiry Report* said that 'ensuring schools better support the social and emotional development of their students, would help children to cope better with challenges arising from the environment they live in, external stressors and the difficulties of growing up'.[89]

The Victorian Government indicated that 'our education settings—our schools, TAFEs and universities—provide important opportunities for early identification, support and referral'.[90] Similarly, the Australian Education Union indicated that 'the mental health of students in schools, preschools and TAFE institutions is as important as their physical health and that there is a clear connection between student wellbeing and learning progress'.[91] Mr Gregory McMahon, Executive Principal of Hallam Senior College and Strategic Director of Doveton College, also spoke of the need for schools to be able to help students connect to mental health treatment, care and support. He noted that '[o]ver a six-year period, Doveton College has recorded 238 students with mental health care needs, leading to formal mental health care plans being put in place for them.'[92]

Some young people also spoke about taking part in education as both a protective and risk factor for their mental health and wellbeing and noted that schools, universities and TAFEs are where they spend a lot of time. In a focus group, one young person explained that:

> growing up, I think there can be a lot of issues that happen at school that can encourage mental ill health. So I think that's why it's really important to realise how much of a big role school plays in young people's lives. [93]

There are already important mental health and wellbeing programs in schools and higher education. For example, the Commonwealth Government has invested in Be You, a $98 million program which 'equips Australian early learning services and schools with the skills and strategies they need to ensure that every child, young person and staff member can achieve their best possible mental health'.[94] The Victorian Government has also committed to every Victorian Government secondary school campus having a suitably qualified mental health practitioner on staff by the end of 2021.[95]

Despite current investments, there are opportunities for better prevention efforts in schools.[96] As outlined in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect,* the Victorian Government will build the capability of government schools to support students' social and emotional wellbeing and to promote positive behaviours.

Teachers and support staff in schools and higher education, including those in formal wellbeing roles, will also be better supported to identify students at risk of, or experiencing, mental health and wellbeing challenges. This will occur through increased funding given to Youth Area Mental Health and Wellbeing Services for primary and secondary consultation. Clinicians from Youth Area Mental Health and Wellbeing Services will 'reach into' secondary schools, universities and TAFEs to build the capability of teachers and support staff, enabling them to support the mental health and wellbeing of more students.

In the future youth mental health and wellbeing service stream, student referral pathways to treatment, care and support will be clearer for teachers and support staff. The referral pathways will be to GPs, paediatricians or directly into the Youth Local Mental Health and Wellbeing Services. GPs or other medical practitioners embedded in schools (such as psychiatrists) will be able to refer students with more complex support needs directly to Youth Area Mental Health and Wellbeing Services.

The Productivity Commission's *Mental Health Inquiry Report* made a range of recommendations to improve mental health and wellbeing in the education sector. In relation to schools, these recommendations included improvements to data,[97] the accreditation of teacher learning,[98] social and emotional wellbeing programs for students[99] and strengthening the monitoring of school performance in improving wellbeing.[100] Recommendations were also made to expand the mental health supports that tertiary education providers offer to their students, including international students.[101]

13.3.2 Strengthening Youth Local Mental Health and Wellbeing Services

Consistent with the new architecture for this service stream described earlier, young people with higher support needs will mostly get support from Youth Local Mental Health and Wellbeing Services.

In the future responsive and integrated system proposed by the Commission, headspace centres will predominantly form the Youth Local Mental Health and Wellbeing Services, although, over time, other providers may also choose to become providers of Youth Local Mental Health and Wellbeing Services.

Headspace has been operating in Victoria since 2006. Between 2014 and 2018, headspace helped 70,637 young Victorians.[102] headspace identifies that '[e]ach centre is run by a local agency which is commissioned by the regional [Primary Health Network] in each location.'[103] Local agencies are a mix of clinical services and non-government providers of psychosocial services.[104]

Many clinicians, service providers and academics spoke about the benefits of fully integrating headspace centres with Youth Area Mental Health and Wellbeing Services.[105] This will occur when an Infant, Child and Youth Area Mental Health and Wellbeing Service is chosen as the lead agency to operate a headspace centre.

Often referred to as 'vertical integration', this ensures the same provider is accountable for operating both services. This means that when a young person asks for help from a headspace centre but has support needs that are more complex than headspace can appropriately manage, they can be referred seamlessly into Youth Area Mental Health and Wellbeing Service.

Vertical integration also responds to the problem of the 'missing middle', which many people raised with the Commission. This arises when a young person's mental health and wellbeing challenges are too complex for headspace and primary care alone but are not complex enough to meet the threshold for treatment, care and support at the area level from specialist services.[106] While difficult to quantify, Orygen has previously estimated that:

> of the 26% of young people in any given year with mental ill-health, around 12% are likely to be experiencing a more moderate to severe and complex mental health issue and may be missing out on [clinical expert] care.[107]

headspace National indicated that:

> Some young people presenting to headspace have complex mental health and social problems and/or are experiencing moderate to severe mental health conditions ... Many of these young people are unable to access the tertiary services they really need because of excessive wait lists, reductions in funding, restrictive eligibility criteria and/or a lack of local, appropriate and youth friendly service options.[108]

Case study:

The Alfred's integrated model with headspace

The Alfred Child and Youth Mental Health Service has operated a vertically integrated service in conjunction with headspace since 2010 to provide support to young people with mental health issues.

Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, said that because the same service provider is accountable for operating both services, it allows them to provide different levels of support to help a broader range of people than a non-integrated service.

> Being responsible for all levels means that we have to make a call. We can't say it's not us because we're accountable for the service delivery for both. headspace is a service for mild to moderate problems, and the state-funded child and youth mental health service is for more severe problems that need a multidisciplinary team.

The integrated service is staffed by a multidisciplinary team including psychiatrists, peer workers, psychologists and allied health professionals. It is available free of charge and can provide support to GPs, school counsellors, community health centres and headspace.

Dr Denborough said an advantage of the integrated model was that it prevented people from having to repeat their story to multiple agencies when they are trying to find the correct service for help.

> It has very deep implications, the main one is if someone rings for help, we try and link them to who's going to do it, rather than ask questions about eligibility and whether they met a certain threshold. This approach changes the whole tone of the conversation, which is around welcoming them and listening deeply to what the concerns are, rather than trying to work out whether they are eligible for service and then turning them away so they have to repeat their story to the next person.

Dr Denborough said while infrastructure and IT supports are shared between the two organisations, there are separate intake processes to determine the level of care needed.

> We have a shared intake with the headspace early psychosis and the headspace primary service. We have another intake with the child and youth mental health service, but because staff all work for the Alfred they speak daily—there's a very close alliance. We decided not to just have one intake mainly because there's different catchment area and age boundaries.

Dr Denborough said using the same provider also reduces the risk of a 'missing middle' gap, which happens when a young person's mental health and wellbeing challenges aren't complex enough to meet the threshold for treatment, care and support at the public specialist mental health services but are too complex to be helped in headspace.

> The advantage of having one governance is by us providing tertiary-level support directly into headspace, we can manage to see people with more complicated problems because the headspace team know that if they really are struggling, we will back them up.

Source: RCVMHS, *Interview with Dr Paul Denborough*, November 2020; Alfred Health, 'Child Youth Mental Health Service' <www.alfredhealth.org.au/services/child-youth-mental-health-service> [accessed 10 November 2020].

Vertical integration is already occurring in some parts of Victoria. For example, Orygen, Alfred Health and Goulburn Valley Health all operate headspace centres. The Australian Medical Association (Victoria) describes the success of the integration model:

> The model at Alfred Health and Goulburn Valley Health includes clinical governance across headspace and [child and youth mental health services], with access to child psychiatrists and well supervised psychiatry trainees. When the lead agency for headspace has been an area mental health service, it has been found to be more effective due to the clinical governance structures and access to child psychiatrists, multidisciplinary teams and trainee registrars.[109]

headspace National also commented on the benefits of vertical integration:

> In some instances, local public health services are the Lead Agencies for headspace centres. headspace National has observed some significant benefits of tertiary mental health services being Lead Agencies for centres, including: (a) Stronger links between headspace and tertiary mental health services which can facilitate the transition of young people's care; (b) Greater access to psychiatry; and, (c) Access to tertiary mental health services' existing clinical governance structures and processes which can greatly benefit the headspace centre.[110]

To realise the benefits of this integration across Victoria, the relevant minister and the Department of Health will work with the Commonwealth Government, headspace National and Primary Health Networks to negotiate an agreement that Infant, Child and Youth Area Mental Health and Wellbeing Services, wherever possible, become the preferred providers for all headspace centres in Victoria. While this should be the goal, if this cannot be realised for some headspace centres, integration should be achieved through formal partnerships outlining support arrangements and referral pathways.

Integration can also be enhanced by prioritising the co-location of Youth Area Mental Health and Wellbeing Services with headspace centres. The alignment of the age parameters of Youth Area Mental Health and Wellbeing Services with headspace will also assist better integration.

Should other providers indicate interest, over time, to become Youth Local Mental Health and Wellbeing Services, the Department of Health will need to consider how to facilitate vertical integration with these services.

With headspace now one of the main entry points into Youth Area Mental Health and Wellbeing Services, it will be critical that the accessibility of headspace is improved. The wait times at headspace centres across Victoria and the negative impacts this is having on young people were raised by many. For example, Youth Affairs Council Victoria indicated that young people in rural and regional areas are often turned away[111] and the CEO of headspace National acknowledged the wait times, giving evidence that:

> In Victorian headspace centres, the average wait time for a young person to have an intake session is 10.5 days, 25.5 days for first therapy session, and 12.2 days for subsequent therapy session. The average wait time for a young person to access eheadspace [digital mental health platform] support is 25 minutes.[112]

Long wait times are a known barrier to help-seeking for young people. International research involving 2,054 young people suggests they are more likely to refuse services and are more likely to drop out of treatment if they face longer wait times.[113] The Commission considers that reducing wait times at Victorian headspace centres should be a priority for headspace National, the Commonwealth Government and Primary Health Networks.

As with all Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services in the future system, and as described in the next section, ensuring services are accessible and responsive to the diversity of local communities is a priority for the Commission. This includes headspaces. Headspace National should consider opportunities to ensure headspace centres are easily accessible and responsive to the diversity of young people who seek their help.

13.3.3 Transforming Youth Area Mental Health and Wellbeing Services

Most young people will receive treatment, care and support in primary and secondary mental health and related services or in Youth Local Mental Health and Wellbeing Services. Youth Area Mental Health and Wellbeing Services will, however, provide treatment, care and support to young people with the most complex support needs. One young person described the need for better services for young people with complex support needs in terms of abandonment:

> While I believe [h]eadspace plays a positive role for many young people, it was insufficient to meet my needs. There was nothing for me in between primary care and the emergency department. As someone with more complex needs, I felt abandoned by the mental health system when I needed it most.[114]

Like adult area mental health services, the current child and adolescent mental health services and child and youth mental health services focus on consumers with the most complex support needs. They differ considerably, however, in their underlying approach. Describing the Child, Youth Mental Health Service at Eastern Health, Ms Allison told the Commission:

> As a specialist mental health service, [we] provide a family inclusive, multidisciplinary, multimodal and intensive psycho-therapeutic approach. Treatment is necessarily broad and needs to attend to the holistic needs of the child or young person. This includes education, community engagement, peer relationships, family dynamics and relationships.
>
> In the [child and youth mental health service] context, recovery is measured as the return to a more normal developmental trajectory with the hope or expectation that for many children and young people they will not need to be ongoing or episodic consumers of specialist mental health services as adults.[115]

In the future service stream, reformed and expanded Youth Area Mental Health and Wellbeing Services will provide developmentally appropriate, multidisciplinary models of care for young people. This includes working directly with young people to increase the accessibility of services and embedding a welcoming, youth-friendly culture that embraces diversity.

This requires four interconnected reforms:

- Youth Area Mental Health and Wellbeing Services will be expanded to increase access to reformed treatment, care and support. This will ensure young people with the most complex needs are not turned away, or accepted as having treatment, care and support needs that require a response from a Youth Area Mental Health and Wellbeing Service, only to have to endure long waits.
- The scope of Youth Area Mental Health and Wellbeing Services will expand to deliver the core functions of community mental health and wellbeing services. These are described in more detail in the context of the adult and older adult mental health and wellbeing system in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*. The core functions include Youth Area Mental Health and Wellbeing Services providing holistic treatment, care and support across clinical, wellbeing supports (previously called psychosocial supports), substance use or addiction support, as well as stronger connections to physical health care and study and vocational support programs.
- Pathways to access Youth Area Mental Health and Wellbeing Services will be changed. This will ensure initial support is provided through primary and secondary care, except for crisis responses.
- Changes to governance arrangements will improve breadth and continuity of care.

Youth Area Mental Health and Wellbeing Services need to reflect the diversity of young Victorians. Many young Victorians come from diverse backgrounds, relating to, for example, country of birth, cultural heritage, gender identity and sexual preferences. In a Commission-led focus group, one young person shared the impact of not having their diversity respected:

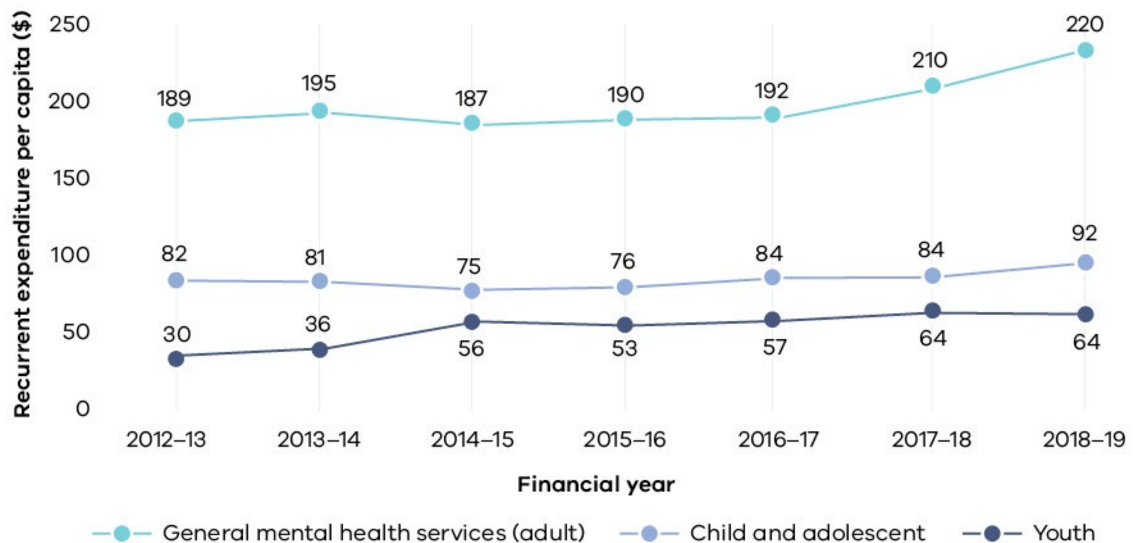
> I found a lot recently, obviously, being trans, that I do suffer a lot of discrimination in the mental health field … exactly a year ago, tomorrow, I was, like, going to the [emergency department] every day for several days trying to get admitted, because my mental health was so bad, and they wouldn't do anything until I eventually, like overdosed. And so, it's horrific. And the woman who did the evaluation and refused to admit me, she was very transphobic and wouldn't use my pronouns. And like, you know, all my medical documents say that I'm male … and she's still refused. So like, just her transphobia, alone could have like, literally killed me.[116]

Youth Area Mental Health and Wellbeing Services must ensure their services are accessible and responsive to all young Victorians. Examples of changes that may be required include increased workforce diversity (for example, employing Aboriginal mental health clinicians), reviewing materials for consumers to ensure they are culturally appropriate, and implementing additional programs or supports for specific groups in their community based on need. Programs and supports in each Youth Area Mental Health and Wellbeing Service will most likely look different to reflect the demographics, strengths, uniqueness and needs of their local communities. The Infant, Child and Youth Area Mental Health and Wellbeing Services will also need to form partnerships with the new Aboriginal social and emotional wellbeing teams, which were recommended in the Commission's interim report.[117]

Increased access to reformed treatment, care and support across Victoria

Over recent years child and adolescent and youth services have consistently received comparatively less funding per capita than adult services, as shown in Figure 13.5.

Figure 13.5: Recurrent expenditure per capita ($) on specialised mental health care services, constant prices, by target population, Victoria, 2012–13 to 2018–19



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Expenditure on mental health services 2018–19, Table EXP.12, <www.aihw.gov.au/reports/mental-health-services/ mental-health-services-in-australia/ report-contents/summary-of-mental-health-services-in-australia> [accessed 29 January 2021].

Notes: Collections and counting rules may have changed over the reporting period. Child and adolescent refers to designated units. Other services may accept child and adolescent clients. Recurrent expenditure includes contributions made by the Victorian and Commonwealth Governments.

The current levels of funding for these services has a direct impact on the number of people who can access services and the amount of treatment, care of support they receive if they do.

As a result, access to community-based care provided by child and adolescent mental health services or child and youth mental health services can be very difficult. This lack of access has far-reaching consequences for young people and their families. For instance, one young person said:

> Orygen was willing to do an assessment but after they did, they told me they couldn't help me and I had to go elsewhere. I told them that I had tried everywhere else—Orygen was my last option and I would die otherwise. They said they would think about it and a few weeks later, I got a call and they did a reassessment and then offered me a service.[118]

The difficulties young people experience in obtaining access to area mental health services is not a localised problem—rather barriers to access are a systemic problem across Victoria. For example, Eastern Health reported that its child and youth mental health service received more than 10,000 calls in a 12-month period and that 3,000 of those calls were abandoned by the caller due to long call wait times.[119] The NorthWestern Mental Health Triage Service and Youth Access Team reported that wait times for an assessment can be several hours.[120]

Mr Trethowan spoke of the difficulties that headspace centres have in referring young people to area mental health services:

> **Many Victorian headspace centres also report that they have limited options when it comes to referring young people to public mental health services. This is because many public mental health services will only accept the most acutely unwell young people, rather than those young people who could benefit from the service.**[121]

The Commission estimates that in 2019–20, 36,000 Victorians aged 12–25 years had a level of need for specialist mental health services equivalent to the three highest-intensity consumer streams described in Chapter 6: *The pillars of the new service system–community-based mental health and wellbeing services*. They are the short-term treatment, care and support stream, the ongoing treatment, care and support stream and the ongoing intensive treatment, care and support stream.

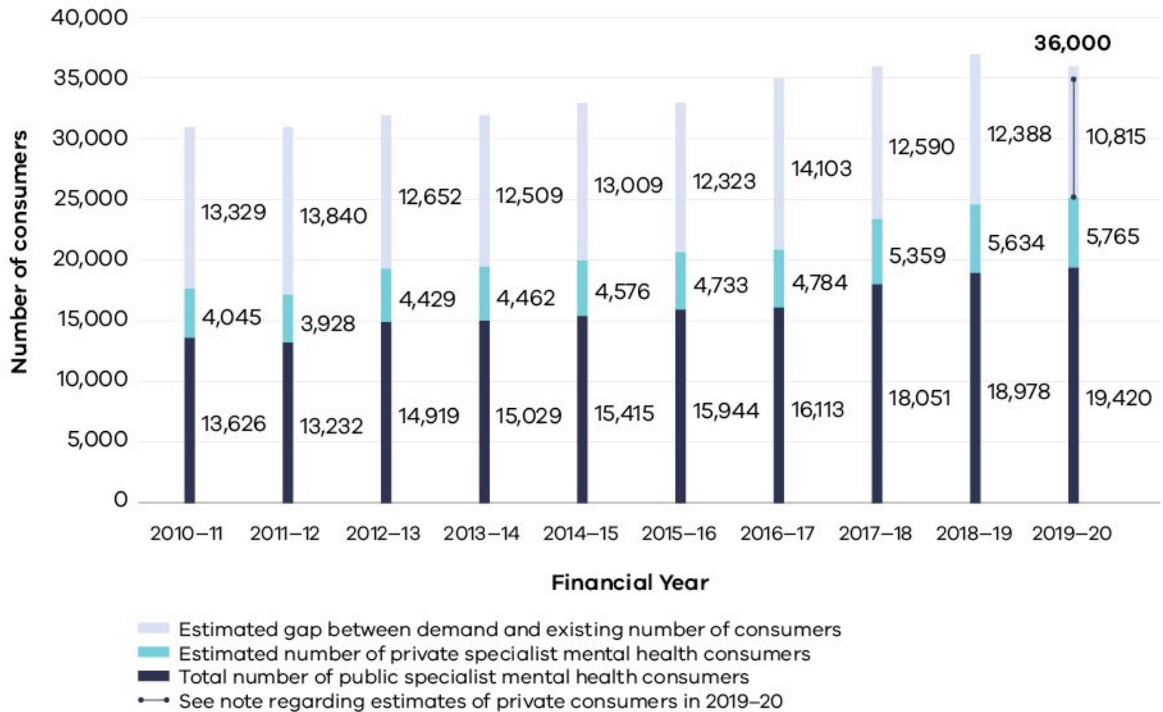
As shown in Figure 13.6, of those 36,000 people, Victoria's current public specialist mental health services saw only 19,420 (53.9 per cent).

Of those 36,000 people, a further estimated 5,765 people (16.0 per cent) to 15,972 people (44.4 per cent) accessed specialist mental health services in the private health system in 2019–20. Private specialist mental health services might include mental health services provided in a private hospital or multiple Medicare-subsidised psychiatric services (refer to Figure 13.6). Such private services are not accessible to all, for example, those with lower incomes or those in areas with limited private sector supply.

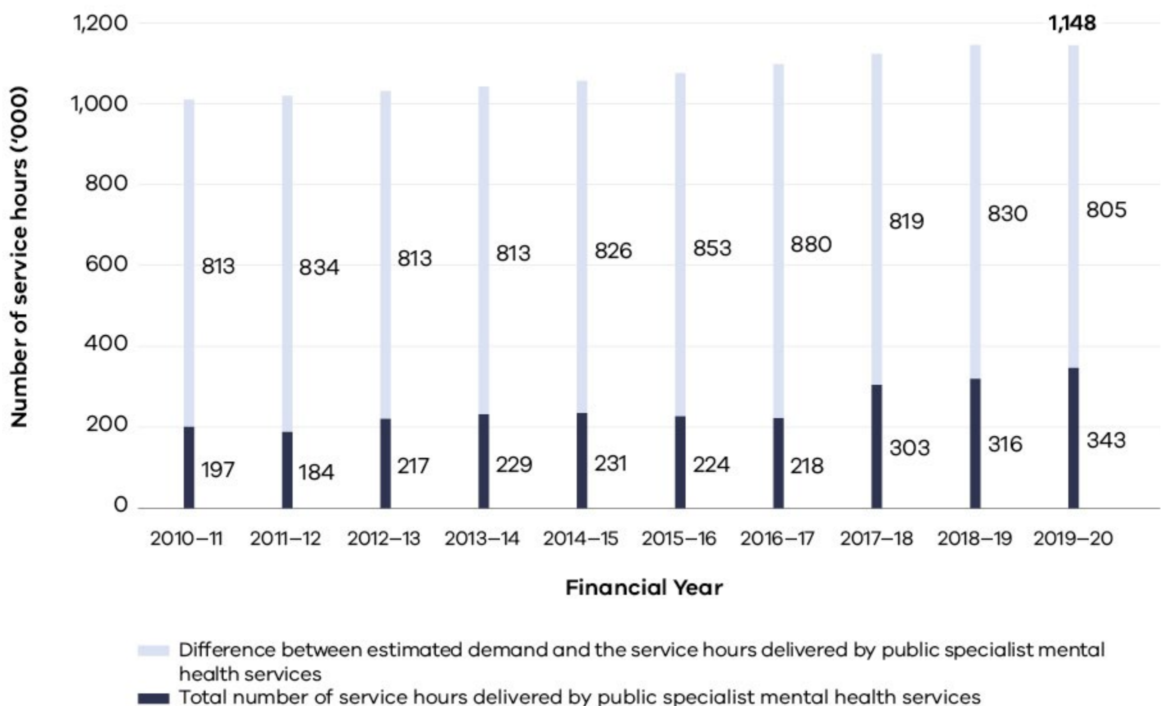
Figure 13.6 also shows the service gap for young people—the proportion of those 36,000 people in 2019–20 who were estimated to require services who did not get them in either the public or private systems. This service gap was estimated to be between 608 people (1.7 per cent) and 10,815 people (30.0 per cent). The second part of the figure shows that in 2019–20 public specialist mental health services delivered only 343,000 (29.9 per cent) of the estimated 1,148,000 hours of care required by young people in Victoria. This measure of unmet demand emphasises that there are substantial gaps in the comprehensiveness of specialist mental health care delivered to young people, even for those who do access services. This data does not include the gaps in access to wellbeing supports.

Figure 13.6: The difference between the actual number of people receiving specialist mental health services/actual consumer-related community service hours delivered and estimated demand, 12–25 years, Victoria, 2010–11 to 2019–20

A. Consumers



B. Service hours



Sources: A. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2018–19; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18; Australian Institute of Health and Welfare, Mental Health Services in Australia: Medicare Subsidised Mental Health-Related Services 2018–19. Table MBS.2.

B. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

A. Consumers: The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology.

This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store which in 2019–20 was 16 per cent of total contacts.

For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers in 2019–20. First, 5,765 consumers which would mean there is an estimated gap of 10,815. This estimate is based on the proportion of people that had a mental health admission to a private hospital only. Second, 15,972 consumers which would mean there is an estimated gap of 608. This includes all people that received more than one service from a Medicare-subsidised psychiatrist or had a mental health-related admission to a private hospital. Anyone that also received public specialist mental health services has been excluded to avoid double counting.

B. Service hours: Some of the gap may be met through services delivered in the private mental health system. Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity, for example, assessment, monitoring, and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

Demand pressures on child and adolescent mental health services or child and youth mental health services mean that young people who have a mental health presentation to an emergency department are not receiving any follow-up for community-based care. Ms Allison indicated that:

> due to the demand for specialist [child and youth mental health services], follow up care and intervention is unable to be offered to all children/young people presenting to our Emergency Departments following a suicide attempt, or suicidal crisis or significant self-harm.[122]

One widespread approach by services to manage demand is that, once accepted, young people often wait some time before they start to receive therapy. Table 13.1 sets out average wait times.

Table 13.1: The current average waiting time between referral and first therapeutic appointment by child and youth mental health service and/or child and adolescent mental health service, Victoria, 2020

Austin Health[1]	Barwon Health	Bendigo Health	Monash Health	The Royal Children's Hospital[5]	South West Healthcare
10 days	3 to 4 weeks	2 to 4 weeks	Child – Early in Life Mental Health Service (ELMHS)[2] Urgency: urgent, 72 hours Urgency: non-urgent, 68 days Youth – Recovery and Prevention of Psychosis Team[3], 6 days Youth Consultation and Treatment Team[4], 12 days	Community teams Urgency: routine, 42 to 63 days Urgency: priority, 12 to 20 days Urgency: crisis/urgent, 2 to 3 days Neurodevelopmental Team, 43 days Clinical psychology, 141 days Developmental neuropsychiatry, 6 months	15 days[6]

Sources: Austin Health, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020; Barwon Health, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020; Bendigo Health, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020; Monash Health, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020; Royal Children's Hospital, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020; South West Healthcare, Response to the Royal Commission into Victoria's Mental Health System's questions to selected area mental health services, 2020.

Notes: 1. Waiting time is before the impact of COVID-19; 2. Urgent cases have been unaffected by COVID-19. Reported non-urgent waiting time is pre-COVID-19. Post-COVID-19 average waiting time is 68 days; 3. Pre-COVID-19 waiting time. Post-COVID-19 waiting time is six days; 4. Pre-COVID-19 waiting time. Post-COVID-19 waiting time is 12 days; 5. Priority allocations are made automatically for certain key consumer groups including Aboriginal and Torres Strait Islander children, children in out of home care or children referred from other parts of the RCH MH. Likewise, crisis/urgent appointments are allocated for children with a significant and immediate level or risk of harm or deterioration as assessed by telephone triage or after assessment in the RCH Emergency Department; 6. The mode is one day. The marked difference between the mean and the mode waiting time is due to delays on a small number of cases (for example, due to further assessment being required for diagnostic clarification, which was needed prior to CAMHS acceptance of the case for treatment). Assessment usually takes place within one to two days of referral (depending on urgency). The data collected only indicate the CAMHS case management acceptance date (after assessment), not the first appointment date. Accordingly, the data provided do not represent the estimated waiting time between assessment and first therapeutic appointment. The data are accurate within a range of one to two days.

Counting methods and sampling approaches vary between health services and may not be comparable. Responses were provided to the Commission between August and October 2020, and services may be partially or fully impacted by COVID-19.

Ms Amelia Callaghan, Director of Clinical Service Innovation at Orygen, who gave evidence in her personal capacity, confirmed that a culture of actively trying to refer young people out has developed as a method of managing demand:

> at the moment we don't have that underpinning philosophy about, yes, we will help you; we actually screen out rather than starting with hope and, yes, let's see how we can help.[123]

Ms Callaghan continued:

> You have tertiary services who are looking for a top threshold, so they take the most severe, and my experience of working in that system was that we would actually try to refer out everyone that we possibly could, even if they were acute or severe: do you have private health cover, do you have the money to pay privately, you know, out they go. Is it a behavioural problem; oh that's not a mental health problem.[124]

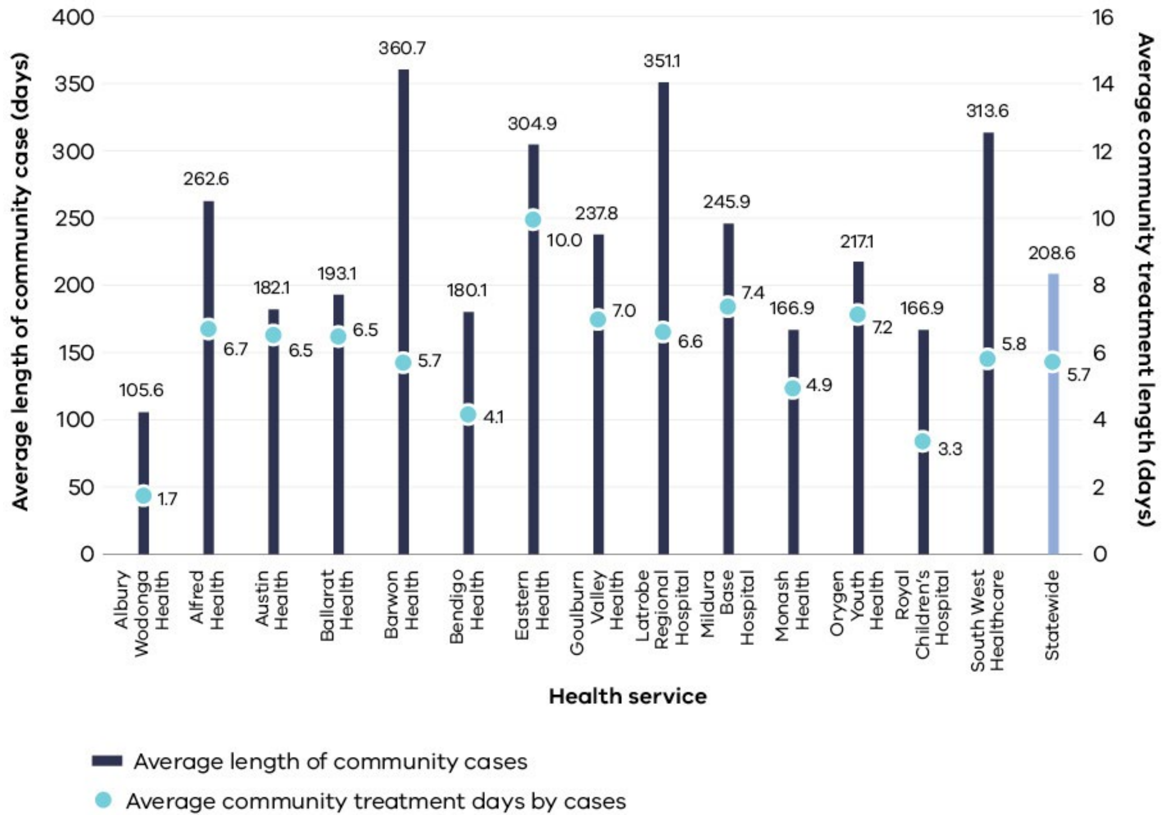
To manage demand, some services also ration the duration of treatment, care and support, even when this reduces the therapeutic benefit for the young person. Orygen indicated that 'under-resourcing and service design has restricted the tenure of care for Orygen Youth Health … patients to a maximum of two years or up to 18 years of age'.[125] In a personal story collected by Victoria Legal Aid, one young person indicated that:

> I really enjoyed Orygen, but I hated the pressure they put on me to be discharged as quickly as possible … I was discharged twice from Orygen. Once at around a year, but was then readmitted due to a relapse, and then another when I eventually finished with Orygen … Young people should be able to get the help they need, for however long they need it. They shouldn't feel pressured to leave.[126]

The data reinforces what the Commission has heard from young people and clinicians. Commission analysis on the average amount of treatment over a given period that young people received from child and adolescent mental health services and child and youth mental health services in 2019–20 shows wide variation across the 13 services.

For example, as shown in Figure 13.7, young people with the most complex support needs at Albury Wodonga Health received on average 1.7 days of treatment across an average of 105.6 days with the service. In comparison, at Goulburn Valley Health consumers received an average of seven days of treatment across an average of 237.8 days with that service. These figures speak to a system providing on average very modest amounts of treatment to those who are able to get services.

Figure 13.7: Average length of community cases and average community treatment days per case, child and adolescent mental health services and child and youth mental health services, by health service, Victoria, 2019–20

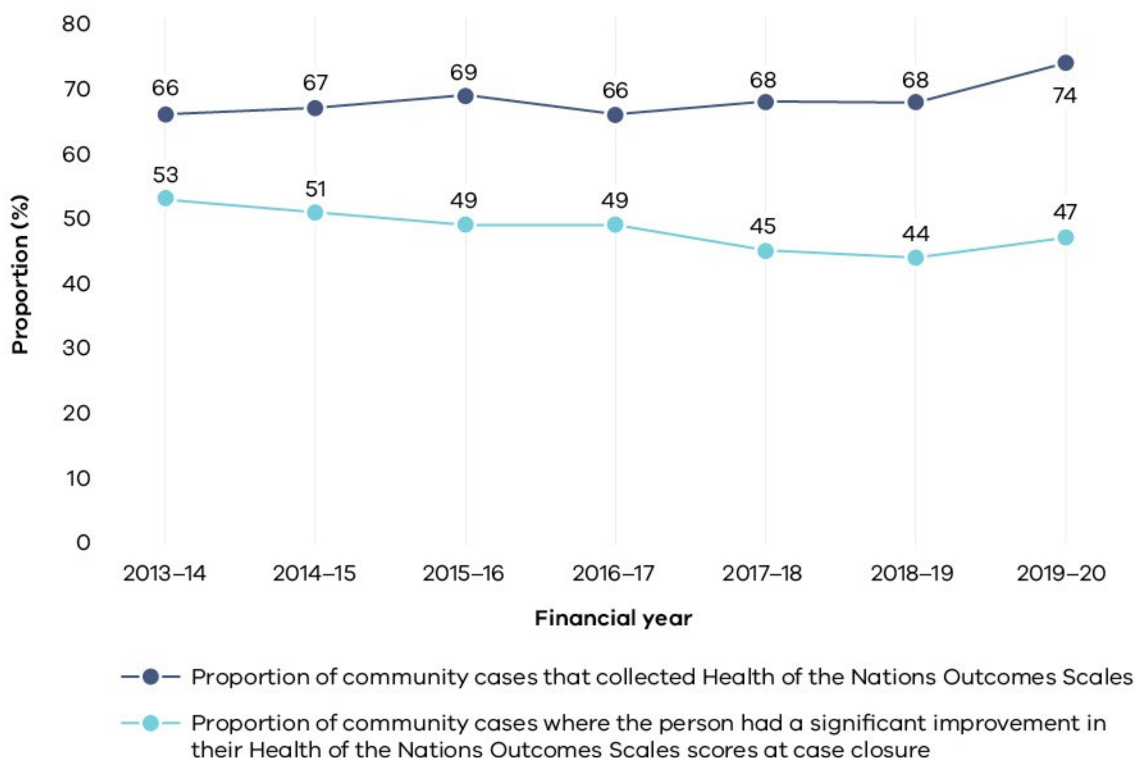


Sources: Victorian Agency for Health Information, CYMHS/CAMHS Mental Health Quarterly KPI Report 2019–20 Q4, 2020, p. 5; Victorian Agency for Health Information, Adult Mental Health Quarterly KPI Report 2019–20 Q4, 2020, p. 8.

Notes: Average length of case (days)—Average length of case (days) for community cases closed during the reference period; Average treatment days—Average number of distinct days with a reportable contact for consumers with an open community case during the reference period, excluding cases open less than 91 days. The statewide results reflect the published numbers in the CYMHS/CAMHS Mental Health Quarterly KPI Report.

The Commission also undertook analysis to understand changes in the mental health of young people following a period of community-based treatment, care and support from child and adolescent mental health services or child and youth mental health services. As shown in Figure 13.8, in 2019–20 less than half of consumers (47 per cent) experienced a positive change in their mental health outcomes (as measured by the Health of the Nation Outcome Scale) as a result of a period of treatment. This is deeply concerning and suggests the system is providing too little and not the optimal types of treatment, care and support.

Figure 13.8: Proportion of consumers with a significant positive change in their mental health following a period of community-based treatment, child and adolescent mental health services and child and youth mental health services, Victoria, 2013–14 to 2019–20



Sources: Victorian Agency for Health Information, CYMHS/CAMHS Mental Health Quarterly KPI Report 2019–20 Q4, 2020, p. 5; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2018–19 Q4, 2019, p. 6; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2017–18 Q4, 2018, p. 4; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2016–17 Q4, 2017, p. 4; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2015–16 Q4, 2016, p. 4; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2014–15 Q4, 2016, p. 4; Department of Health and Human Services, CYMHS/CAMHS Mental Health Quarterly KPI Report 2013–14 Q4, 2016, p. 4.

Notes: HoNOS compliance—Percentage of required collection events in a community setting where a HoNOS outcome measurement scale (HoNOSCA/HNSADL) was completed, excluding invalid HoNOS scores (more than two times rated as '9'); Cases with significant improvement at closure—Percentage of completed community cases with a 'significant' (cases with a change of score greater than half of a standard deviation of all changes in scores) positive change calculation between case start and case end.

Excludes Orygen Youth Health. Data presented represent the Department of Health and Human Service's CYMHS/CAMHS key performance indicators. Orygen Youth Health is reported as part of the adult suite of indicators.

To respond to the factors detailed above, Youth Area Mental Health and Wellbeing Services will be expanded so they can help more young people with complex support needs. Figure 13.9 outlines the Commission's estimates of the number of 12–25-year-old consumers in each of the consumer streams over a 12-month period in 2020–21.

Figure 13.9: The estimated number of people requiring mental health treatment, care and support over a 12-month period, by stream, aged 12–25, Victoria, 2020–21

At any given point in time, a person living with mental illness or experiencing psychological distress will need to be able to access treatment, care and support in one of five intensity-based streams:	Estimated of number of people aged 12–25 in 2020–21
Communities and primary care stream	**190,000**
Primary care with extra supports stream	**45,000**
Short-term treatment, care and support stream	**19,000**
Ongoing treatment, care and support stream	**10,000**
Ongoing intensive treatment, care and support stream	**7,000**

Sources: Commission analysis of the Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Department of Environment, Land, Water and Planning, Victoria in the Future 2019.

Note: Streams are adapted from Harvey Whiteford and others, 'Estimating the Number of Adults with Severe and Persistent Mental Illness Who Have Complex, Multi-Agency Needs', *Australian and New Zealand Journal of Psychiatry*, 51.8 (2017), 799–809. Care profiles from the *National Mental Health Service Planning Framework* have been mapped to the streams.

The estimated 36,000 young consumers in 2020–21 across the 'Short-term treatment, care and support', 'Ongoing treatment, care and support', and 'Ongoing intensive treatment, care and support' streams will, in future, be able to obtain the bulk of their treatment, care and support through a combination of Youth Local Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services. The higher the intensity of needs, the greater the proportion will be the responsibility of Youth Area Mental Health and Wellbeing Services.

As described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, the Commission has developed these estimates of the number of people likely to need to access each consumer stream throughout the 2020–21 financial year. These are based on the *National Mental Health Service Planning Framework*.[127] As discussed in Chapter 28: *Commissioning for responsive services*, the Victorian Government will establish a process for assessing the Victorian population's need for mental health and wellbeing services by initially using a substantially adjusted version of the *National Mental Health Service Planning Framework*. Given this, the estimates in Figure 13.9 should only be viewed as a starting point.

Substantial ongoing investment will be required to bridge the gaps described above between demand and the current capacity of child and adolescent mental health services and child and youth mental health services. Once fully implemented, service expansion will ensure young people and their families receive appropriate services in a timely manner and without restrictions on length of care.

In addition, the Department of Health will work with Regional Mental Health and Wellbeing Boards to determine the optimal longer term funding levels for the Youth Area Mental Health and Wellbeing Services through the needs assessment, demand modelling and planning process described in Chapter 28: *Commissioning for responsive services*.

Reformed core functions

All Youth Area Mental Health and Wellbeing Services will deliver the core functions of community mental health and wellbeing services. This will ensure better consistency in what young people can access, regardless of where they live. It also enables a much broader range of services to be delivered that will better meet young people's needs.

As described in Chapter 5: *A responsive and integrated system*, Infant, Child and Youth Area Mental Health and Wellbeing Services will be delivered through partnerships between public health services or public hospitals and non-government organisations that provide wellbeing supports. The delivery of the below core functions will be shaped by those partnerships.

The 'community mental health and wellbeing services core functions' are shown in Figure 13.10

Figure 13.10: Community mental health and wellbeing services: core functions

The core functions outline the expectations regarding the support young people will consistently be able to get when receiving community-based care. They will be delivered by all Youth Area Mental Health and Wellbeing Services. Where possible, Youth Local Mental Health and Wellbeing Services, including headspace centres, should look to also align their approaches to the community mental health and wellbeing services core functions. The core functions are explained in most detail in Chapter 7*: Integrated treatment, care and support in the community for adults and older adults*.

The implications for the Youth Area Mental Health and Wellbeing Services of delivering the community mental health and wellbeing services core functions are outlined below.

Core function 1: Integrated treatment, care and support across four components

Under the first core function, the range of services that Youth Area Mental Health and Wellbeing Services deliver will be considerably expanded, and the range offered will be more holistic and contemporary.

This expansion in the range of services offered by Youth Area Mental Health and Wellbeing Services aligns with evidence of best practice and responds to feedback from young people. For example, one young person shared:

> you're looking at, like, physical health, alcohol and drug, like study, psychosocial … they're protective factors for relapse, and also kind of the functional side of recovery. So I think it's really important to have, you know, the therapy, but I think you need all the other factors kind of to facilitate recovery, functionally.[128]

1.a: Treatments and therapies

Clinical treatment remains a major part of providing a high-quality service to young people. This core function sets a high ambition for the breadth and quality of treatments and therapies available, and their integration with other domains such as wellbeing supports and substance use or addiction support.

In the future, Youth Area Mental Health and Wellbeing Services will offer a broad range of therapeutic interventions and treatments, which will include psychological therapies, pharmacological therapies, trauma-informed therapies, speech therapy, occupational therapy and arts and creative therapies. For more detail on what is specifically covered in each, refer to Chapter 7: *Integrated treatment, care and support in the community for adults and older adults.*

The need to offer a broader range of interventions and treatments responds to evidence from young people, families, carers and supporters, who spoke of only currently being able to get a small range of therapies. For example, one family said that:

> transcranial magnetic stimulation (TMS) should be available through public mental health hospitals or as an outpatient. The early evidence shows that TMS has been helpful with depression and for Thea she sees TMS as a treatment that provides some hope for improving her life. We have not yet been able to access TMS.[129]

As well as limitations on the types of therapies available, young people and clinicians also indicated that demand pressures often reduce the amount of therapy they can access. One young person shared:

> Some services, although few and far between, offer therapy. At one place I was offered dialectical behaviour therapy (DBT) which I thought was great. I was, however, eventually kicked out of the DBT program because I was told I was too complex. Other services I would go to had no forms of therapy. In those services, all that happens is you see your case manager once a week or once a month and have a review every three months with a psych ... Therapy should be available to everyone, at every service.[130]

Similarly, Thea's family also shared their experience of trying to advocate for their daughter's therapy to be increased:

> [Child and youth mental health services] appeared to be unable to find solutions to Thea's suicidal behaviour and we feel she was put in the too hard basket. Once a fortnight, therapy sessions were conducted which in our view were clearly inadequate to treat Thea's Borderline Personality Disorder. We were pushing for Thea to receive formal Dialectical Behaviour Therapy (DBT), but the service felt their treatment was good enough. Thea has been told that she will not receive treatment until she stops her suicidal behaviour. This is putting the cart before the horse. They seem to be saying that Thea won't be treated until she gets better![131]

The often-limited time that clinicians get to spend on delivering therapy was also commented on by Professor David Coghill, Financial Markets Foundation Chair of Developmental Mental Health at the Royal Children's Hospital, who gave evidence in a personal capacity:

> within child and adolescent, child and youth mental health services, an awful lot of the work is taken up in providing case management, which takes away time from direct ... assessment and treatment.[132]

Youth Area Mental Health and Wellbeing Services will need to consider how best to ensure that clinician and support worker time is appropriately balanced between delivering clinical interventions and undertaking care coordination type activities—both of which are important when helping a young person.

In a major expansion to the scope of Youth Area Mental Health and Wellbeing Services, integrated care will now be provided for young people living with mental illness and substance use or addiction. This is in recognition of the high levels of co-existing mental health and wellbeing and substance use or addiction challenges. For example, alcohol and other drug support provider service data for 2018–19 suggested that around 61 per cent of young people aged 12–25 years old (3,652 out of a total of 6,001) being supported by alcohol and other drug support providers had also been diagnosed with a mental illness.[133]

As described in detail in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*, this means that young people who seek help from Youth Area Mental Health and Wellbeing Services, and have both mental health and substance use or addiction challenges, will be offered integrated care by the Youth Area Mental Health and Wellbeing Service. They will no longer have to seek mental health treatment from one service and then separately seek substance use or addiction support from another service.

In the current system, youth alcohol and other drug providers told the Commission that while they try and support the mental health needs of young people as best they can, rarely are they able to get the help of child and adolescent mental health services or child and youth mental health services to jointly support the young person. For example, Youth Support and Advocacy Service indicated that:

> YSAS [Youth Support and Advocacy Service] now support an increasing number of young people with highly complex mental health needs that coexist with other issues and challenging behaviours, in the absence of other available treatment options. Many of these young people also have extensive previous involvement with mental health and other social support services. YSAS wants to work with these young people but they require specialised wraparound supports delivered into their community and residential settings. Such services are extraordinarily hard to access for all but the most severe clients.[134]

Under this core function, Infant, Child and Youth Area Mental Health and Wellbeing Services will need to determine how they deliver this integrated care. That may include employing dual-diagnosis clinicians within their multidisciplinary teams or forming a fully integrated partnership with a youth alcohol and other drug provider (with this partnership ensuring that the young person is helped from the same service).

The Commission also heard evidence of poorer physical health outcomes for people with mental illness.[135] The 2007 National Survey of Mental Health and Wellbeing suggested that around one third of young people living with a mental illness had two or more disorders, either a physical and 'mental disorder' or more than one 'mental disorder'.[136] Further, young people living with a mental illness are twice as likely as those without a mental illness to smoke (38 per cent compared with 16 per cent).[137]

In response to the evidence of poorer physical outcomes, across all age groups, Youth Area Mental Health and Wellbeing Services will ensure they discuss and understand a person's physical health needs as part of care planning and coordination. These discussions should occur at the initial intake stage and regularly throughout their treatment, care and support in case their needs change. Youth Area Mental Health and Wellbeing Services will also proactively connect people they are helping to general practice, including GPs and practice nurses available in community health centres and headspaces.

The Commission is also aware that some of the existing area mental health services already employ physical health clinicians as part of their multidisciplinary teams, such as speech pathologists and exercise physiologists. The Commission encourages all Infant, Child and Youth Area Mental Health and Wellbeing Services to consider the value of employing physical health clinicians in their teams.

As noted earlier and in other chapters, Youth Area Mental Health and Wellbeing Services will be expanded to better meet demand. This expansion is likely to mean that Youth Area Mental Health and Wellbeing Services will need an expanded physical footprint. This provides an opportunity for co-location with other services young people use, such as general practice, which would further encourage integration between mental and physical health.

Newly established specialist trauma practitioners will also support young people with trauma histories by becoming, where required, part of their multidisciplinary care team. Working alongside peer support workers, trauma practitioners will support young people, families, carers and supporters to develop a therapeutic recovery plan which facilitates clinical and non-clinical options for treatment, care and support. As described in Chapter 15: *Responding to trauma*, these specialist trauma practitioners will be embedded within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services and will be governed by the clinical governance of those services. They will also 'reach in' and support Youth Local Mental Health and Wellbeing Services, including headspace centres, through primary and secondary consultation. This initiative will help increase the focus on, and effectiveness of, integrated treatment and therapies.

To deliver this increased range of treatments and therapies, Infant, Child and Youth Area Mental Health and Wellbeing Services will need to re-assess the composition of their multi-disciplinary teams and their core competencies. Targeted recruitment may be necessary in some disciplines such as family therapists and music and art therapists. All Infant, Child and Youth Area Mental Health and Wellbeing Services will require an increase in the number of youth peer workers employed, noting that in many services, current numbers of youth peer workers are small. Ms Allison noted that:

> [the] lived experience workforce is emerging within [child and youth mental health services] but is currently largely unfunded, with the significant investment to date directed to adult mental health services.[138]

1.b: Wellbeing supports (formerly known as psychosocial supports)

As a system-wide objective, the Commission aims to rebalance Victoria's mental health and wellbeing system to ensure a balanced focus on clinical care and treatment and wellbeing supports. This reflects the need to help young people experiencing mental health challenges in a much more holistic way. It also recognises that social factors contribute to, and exacerbate, poor mental health. As well as significantly improving mental health outcomes, this rebalancing enables young people to live well across aspects of their life that are important to them.

In the future, wellbeing supports must be regarded as important as clinical services and integrated fully into treatment, care and support. This is a major reform and will require change at the system, resource and culture levels. As described in Chapter 5: *A responsive and integrated system*, Infant, Child and Youth Area Mental Health and Wellbeing Services will be governed through partnerships between a public health service or public hospital and a non-government organisation that provides wellbeing supports. That reform means all core functions will be delivered by a partnership. It makes it organisationally easier for these services to provide wellbeing supports tailored to each young person's needs, strengths and preferences.

The Commission heard from young people about how much wellbeing supports can help. One young person spoke of being connected to Mind Australia's wellbeing supports program after they called the Kids Helpline:

> Since I've been with Mind, I've become more outgoing, I'm out of the house and socialising. I barely attended any groups with Mind in the beginning, but they've pulled me out of my shell and they've done so in a way that hasn't hurt or damaged me.[139]

A focus on wellbeing supports also recognises that it is difficult for young people to focus on their recovery if fundamental aspects of their life (such as where they live and their financial security) are uncertain. The Youth Support and Advocacy Service indicated that:

> **Some degree of stability in life circumstances is a precondition to being able to gain control over the range of mental health problems and a range of health compromising issues and behaviours.**[140]

What constitutes a wellbeing support is broad. Mind Australia describes wellbeing supports as those 'that aim to assist people with the practical and emotional support they need to gain/regain a productive and meaningful life'.[141] For young people, wellbeing supports typically focus on study, employment, housing and life skills to foster independence and connections into communities. A 2016 review by the University of Melbourne's Centre for Mental Health suggested there is strong evidence that social skills training, supported employment and supported housing are all likely to promote recovery.[142] Wellbeing supports must respond to young people's current life circumstances and support them to achieve goals of their choosing.

Some child and youth area mental health services already provide some psychosocial supports. For example, Dr Denborough indicated that the Alfred has 'contracted through Launch Housing a housing worker, so actually having these workers working within our team does provide a really broad and, I suppose, responsive service'.[143] However, the integration of psychosocial supports is fairly limited and often dependent on the importance that executive staff of individual services place on psychosocial supports.

Education and employment supports are essential wellbeing supports for young people. Research suggests that young people experiencing mental illness are more like to leave school earlier and have poorer employment outcomes.[144]

Youth Area Mental Health and Wellbeing Services will have a critical role in connecting young people to existing education and employment supports as part of the care planning process. They are expected to partner with local employment services and community providers working with young people to assist them to identify and achieve their education and employment goals. These goals may include returning to school to complete Year 12 or equivalent, enrolling in a training course or university, finding a mentor or finding and keeping a job. Ms Juniper described how valuable it was when Orygen Specialist Program supported her to reconnect with education:

> **Getting vocational help was important. The vocational workers [at Orygen] helped me find a pathway to university even though I had stopped going to school.**[145]

In addition to Youth Area Mental Health and Wellbeing Services forming local partnerships to better support young people with mental health and wellbeing challenges to find and stay in employment, the Commission also supports the recommendations of the Productivity Commission's *Mental Health Inquiry Report* that relate to the Individual Placement and Support program.

The Productivity Commission recommended that '[t]he Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all relevant State and Territory Government community ambulatory mental healthcare services.'[146]

The Individual Placement and Support program is an intensive employment program that integrates employment support with clinical mental health services as part of young people's care plans, on an opt-in basis. Under the program, an employment specialist is embedded into the multidisciplinary team providing treatment, care and support to the young person and works directly with them to achieve their vocational goals.[147]

The Productivity Commission noted that both levels of government would benefit from a broader rollout of the Individual Placement and Support program and that '[t]his suggests a cooperative funding model for IPS services could be established—potentially through a national partnership.'[148] The Commonwealth Government currently funds a trial of the Individual Placement and Support program in 50 headspace centres nationally, including in headspace centres in Victoria.[149]

If Commonwealth Government co-funding can be secured, the Commission supports the Individual Placement and Support program being incorporated into the new model of care within the service stream of Youth Area Mental Health and Wellbeing Services.

A 2019 international meta-analysis of randomised control trials of the Individual Placement and Support program suggested the model is effective in promoting access to employment.[150] Evidence indicated that:

- employment rates were more than doubled in Individual Placement Support compared with standard vocational rehabilitation
- outcomes were not affected by the regulation of temporary employment, the generosity of disability benefits, the type of integration policies or a country's gross domestic product, unemployment rate or employment rate for those with low education
- efficacy can be generalised between countries.[151]

The proposed 13 youth recovery colleges, described further below, will also have various courses that young people can use to build their life skills.

1.c: Education, peer support and self-help

Under this component, a youth recovery college (or 'youth discovery college') will be established in each Youth Area Mental Health and Wellbeing Service. Enrolment in the courses offered by the youth recovery college will be free and open to anyone—including young Victorians receiving treatment, care and support at any youth mental health service, families, carers and supporters, and people who work in youth mental health.

Recovery colleges are an education-based approach to supporting mental health recovery through a framework of shared learning and co-production. Recovery colleges create a place where everyone is welcome to enable 'learning from each other, sharing experiences and ideas to explore who we are, what works for us, what we want and what we can do'.[152] They are described in detail in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

1.d: Care planning and coordination

In the future system, young people with the most complex support needs will receive care planning and coordination proportionate to their strengths and needs. Services will organise, plan and coordinate the support young people will receive (as described under the other core functions of treatment, care and support). This approach will be aligned with this function for the adult and older adult system as described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

Services will ensure young people experience greater continuity of care during transitions, in periods between episodes of care and when moving between services. Young people will be the central focus of discussions. This includes initial discussions about their strengths and needs, discussions about their current circumstances, review discussions and discussions at transition points—for example, discharge after a stay in hospital.

Care planning and coordination will, therefore, be person-centric and support young people's consumer agency. This means that the consumer's voice, the meaning people place on their experiences, and the social circumstances they are living in will be central to conversations and discussions. Families, carers and supporters will be engaged and supported by the service and involved in ways that are appropriate (noting that level of involvement may differ based on the young person's age).

Core function 2: Services to help people find and access treatment, care and support and, in area services, respond to crises 24 hours a day, seven days a week

As described earlier, most young people who need treatment, care and support will initially be helped by primary and secondary mental health and related services. Young people with higher intensity needs will be helped by either Youth Local Mental Health and Wellbeing Services or Youth Area Mental Health and Wellbeing Services.

As described earlier in this chapter, it is the Commission's vision that Youth Local Mental Health and Wellbeing Services will be more accessible to young people, offering soft and welcoming entry points, with no or limited barriers to access and minimum waiting times. This will assist young people to more easily find their way into the youth mental health and wellbeing service stream when they ask for help.

Consistent with the all-ages approach outlined in Chapter 8: *Finding and accessing treatment, care and support*, access to the Youth Area Mental Health and Wellbeing Services will be managed more tightly through a new referral system. Unless young people are experiencing a crisis requiring an urgent response, they will need a referral from a medical practitioner (such as a GP, psychiatrist or paediatrician) or a Youth Local Mental Health and Wellbeing Service (for example, headspace). The aim of this reform is to preserve the resource-intensive, highly specialised resources in Youth Area Mental Health and Wellbeing Services for those who most need them.

As explained in Chapter 9: *Crisis and emergency responses*, area-level services will respond to requests for crisis assistance from any member of the community, 24 hours a day, seven days a week. Each Area Mental Health and Wellbeing Services will collaboratively decide on the best service configuration to deliver age-appropriate crisis responses across the 24-hour cycle.

The Commission recognises that it is desirable to have crisis responses that are developmentally appropriate. However, the Commission also acknowledges that significant resources are required to provide a 24/7 response and that high volumes would be required to justify the costs of staffing associated with such a response. Infant, Child and Youth Area Mental Health and Wellbeing Services should carefully consider, in consultation with the Department of Health, whether their service meets the level of volume to justify a specialist response for infants, children and young people. In other areas, Adult and Older Adult Area Mental Health and Wellbeing Services may provide whole-of-life crisis responses with clinicians and support workers drawn from infant, child, youth and adult specialties. The Department of Health should monitor these arrangements and review them should demand for 0–25 crisis responses necessitate an increase in dedicated responses for infants, children and young people.

Through the reforms described in Chapter 9: *Crisis and emergency responses*, the Commission has recommended that the Victorian Government invest in diverse and innovative 'safe spaces' and crisis respite facilities. To provide young people with more options when they are experiencing a crisis, this includes up to four safe-space facilities across the state, comprising a mix of drop-in spaces and crisis respite services, co-designed with and specifically for young people.

Core function 3: Support for primary and secondary services

Primary, secondary and related services have a central role in the Commission's responsive and integrated service system and are where most young people will be seen and provided with treatment, care and support. To support them to perform this role, Youth Area Mental Health and Wellbeing Services will provide primary consultation to consumers, secondary consultation to these services and comprehensive shared care. A detailed explanation of these models in the context of the adult system is in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

Youth Area Mental Health and Wellbeing Services will develop models of support that are best suited to their local contexts. Priority should be given to working with:

- GPs, paediatricians and private psychologists and psychiatrists
- secondary schools, including mental health clinicians and doctors embedded in secondary schools
- wellbeing and support staff located within higher education facilities
- child protection principal practitioners and Child FIRST/The Orange Door practitioners
- clinicians and support workers in Take Two
- Aboriginal community-controlled health services
- youth alcohol and other drug service providers (in particular, in relation to withdrawal and rehabilitation services).

Support for primary and secondary care and related services is where clinicians from Area Mental Health and Wellbeing Services 'reach in' and work directly with consumers, clinicians and support workers in these services. There are several existing models in Victoria. Core activities generally include:

- giving second opinions on assessments and input into treatment plans and medication reviews (when the area-level clinician sees the young person, this is referred to as primary consultation, when this advice is provided via a discussion with the clinician or support worker, it is referred to as secondary consultation)
- providing shared clinical care where the primary or secondary care clinician or support worker and the clinician or support worker from the area-level service deliver treatment, care and support together
- working directly with clinicians and support workers in primary and secondary care to build their capability—for example, through case review, observation, role-playing and behaviour modelling.

In relation to shared care, under this new model GPs and paediatricians (for young people under 18) continue to support the young person. They will, however, be supported by clinicians in Youth Area Mental Health and Wellbeing Services, who work with the GP and paediatrician to support certain aspects of the young person's treatment, care and support. While this report does not specify a specific shared care model to be implemented, an example of a successful model services may adopt is the Consultation-Liaison in Primary-Care Psychiatry model. This model was developed in Australia in the 1990s to link GPs with mental health specialists to assist in providing shared care to consumers with complex mental health support needs.[153] More information on successful shared care partnerships is contained in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

The benefits of this include that more consumers can be supported in these settings, avoiding the need for them to use Youth Area Mental Health and Wellbeing Services, as discussed in relation to Figure 13.11. In addition to the benefits for the young person, this is an effective way for Youth Area Mental Health and Wellbeing Services to prioritise their resources. Further, support for primary and secondary care and related services acts to support closer working relationships between those services and Area Mental Health and Wellbeing Services. It also develops referral pathways and builds relationships between clinicians. This assists with transfer of knowledge and can prevent consumers having to retell their story.

Figure 13.11 depicts analysis undertaken by the Commission of the levels of service utilisation of young people during episodes of treatment, care and support in public specialist mental health services (both bed-based and community services) in 2017–18. On the left-hand side is the 2,500 young consumers in 2017–18 who accessed Medicare-subsidised mental health services in the community the *most*, while also accessing public specialist mental health services. On the right-hand side is the 2,500 young consumers in 2017–18 who accessed Medicare-subsidised mental health services in the community the *least*, while also accessing public specialist mental health services.

The group shown on the right, who accessed Medicare-subsidised mental health services in the community the least, used public specialist mental health services far more often that year. While this data should be interpreted with caution, it may indicate, for young people who have successfully accessed public specialist mental health services, an inverse relationship between the use of Medicare-subsidised mental health services in the community and level of need for public specialist mental health services.

Expanding the modes of service delivery

The range of ways Infant, Child and Youth Area Mental Health and Wellbeing Services deliver treatment, care and support will be expanded, giving young people more choice about how they are helped and enabling them to be helped more effectively.

Clinic-based services will remain the main mode through which young people obtain their treatment, care and support. Through a co-design process with young people, families, carers and supporters, Youth Area Mental Health and Wellbeing Services will explore ways to increase their accessibility.

This should include exploring ways to extend the use of telehealth (where safe and the preference of the young person) and to extend service operating times to promote greater family, carer and supporter inclusion and to support consistency with study and work. The current heavy focus on clinic-based appointments and standard operating hours of 9am to 5pm five days a week can make it hard for young people to get treatment, care and support. One young person said:

> Services should be more flexible in the times they are open. This would help young people access these services.[154]

Ms Allison agreed that this was a problem, giving evidence that:

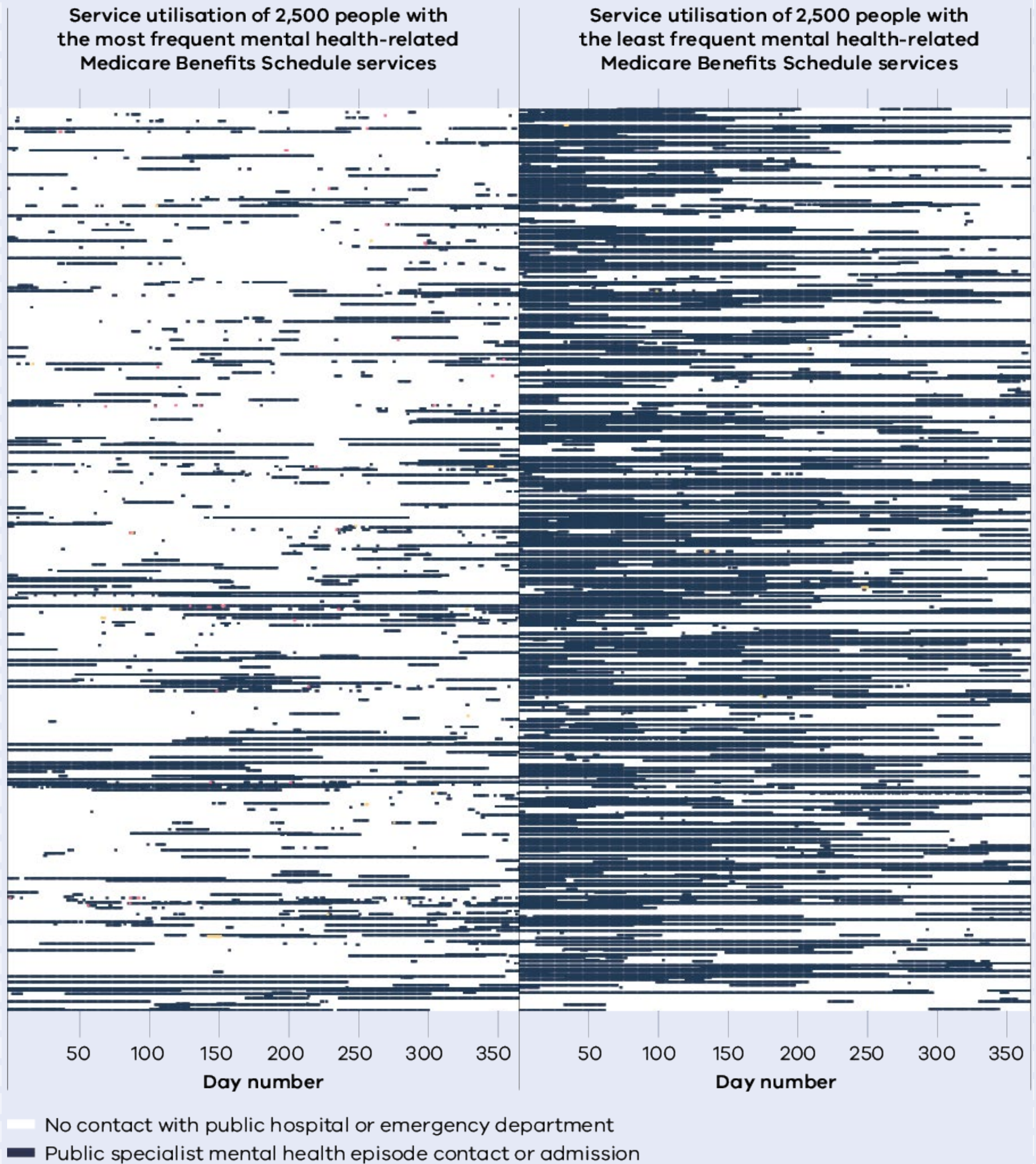
> Office based services do not always sit well with the needs of vulnerable children or young people, and their families. Parents can also struggle to juggle work commitments with attendance at appointments. [Child and youth mental health services] need greater capacity to be able to offer appointments outside of office hours, alongside greater outreach or in-reach services in those circumstances where office based work is not suitable.[155]

Digital mental health services will become a feature of Youth Area Mental Health and Wellbeing Services, noting that there is strong acceptance of digital mental health services among young people, provided they are accessible, safe and integrated with face-to-face therapy.[156] Digital mental health services are those that use a broad range of digital technologies (such as social media, mobile technologies, wearable devices and mobile applications) and can provide integrated, real-time 24/7 support.[157]

Headspace confirmed in its submission that its digital mental health platform—eheadspace—has been well used by young people:

> headspace has demonstrated that young people can and will readily engage in online options, and that these are particularly powerful when they form part of an integrated approach with face-to-face delivery.[158]

Figure 13.11: Service utilisation of public hospital and emergency departments by public specialist mental health system active clients aged 12–25 years, that used Medicare-subsidised mental health services by frequency, Victoria



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Information System/Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2017–18.; Government Services Australia, Medicare Benefits Schedule 2017–18.

Notes: Each line is an aggregate of five people and their service utilisation in 2017–18 by day. In order to preserve the patient level trends whilst protecting privacy regulations, the aggregated records reflect the most frequent service setting on each day for the five individuals within each sample. When there is an equal number of most frequent settings, then preference is given to the public specialist mental health system (inpatient or community), followed by non-mental health public admissions and then mental health related emergency presentations. The data excludes people that used private hospitals and people where there was no mental health diagnosis recorded. Different colours represent different settings. Purple bars represent public specialist mental health episode contacts or admissions. Yellow bars, where they appear, represent non-mental health public hospital admissions. Pink bars, where they appear, represent mental health related emergency department presentations.

Professor Mario Alvarez-Jimenez, Director, Orygen Digital, told the Commission that digital technologies assist in providing seamless, integrated services to young people:

> digital technologies are not just about plugging gaps, but also improving upon the current interventions (e.g., by increasing their potency and treatment effects).[159]

Professor Alvarez-Jimenez went on to describe young people's expectations:

> young people demand a one-stop mental health solution that seamlessly integrates digital interventions with face to face services.[160]

Steps are already being taken to integrate digital mental health services into young people's treatment, care and support in Victoria. In April 2020, the Victorian Government announced funding for Orygen to implement its MOST (Moderated Online Social Therapy) program across all state-funded child and adolescent youth mental health services and all Victorian headspace centres by mid-2021.[161] MOST provides tailored online therapy and clinician and peer support via a digital platform.[162] This innovative program of work will see the same digital mental health service fully integrated with the face-to-face therapy young people will receive in headspace or Youth Area Mental Health and Wellbeing Services.

The Commission welcomes this investment in digital mental health services. It is a critical and important step towards strengthening Victoria's youth mental health and wellbeing service stream.

In this investment in the MOST (Moderated Online Social Therapy) program, the Victorian Government has chosen a provider model that involves different organisations involved in delivery. This may introduce some structural hurdles. In circumstances where different organisations are providing the face-to-face and online care, the two forms of care must be truly integrated. The Department of Health should carry out a comprehensive review of the model as soon as possible after its initial establishment to identify any implementation challenges, to ensure the service is integrated and to inform future changes to the program.

In the future, Youth Area Mental Health and Wellbeing Services will also provide targeted mobile assertive outreach services. These services will be a targeted, short-term mode of delivering treatment, care and support, available to a small number of young people. This includes young people who will not attend clinic-based services, who find it difficult to deal with treatment or who have disengaged from treatment. The Australian Medical Association (Victoria) confirmed the effectiveness of this type of service:

> Services which offer outreach appointments to engage young people and their families in familiar environments, with existing workers with whom they feel emotionally safe, generally work well.[163]

It can be difficult for some young people to connect with the child and youth mental health services using traditional methods such as clinic-based appointments. Professor McGorry said this can be because of their experiences of mental illness or psychological distress, as well as a range of other factors, including the stigma associated with mental illness:

> A lot of young people who are developing mental health problems will not necessarily be able to get over the moat and seek help; they may be house bound with anxiety, paranoia, psychosis or other mental health problems. The Royal Commission will be judged in part upon how successfully it reinvents, revitalises and redesigns the mobile assertive care world.[164]

Mobile assertive outreach is more flexible, assertive and intensive than traditional clinic-based treatment. The mobile teams use a range of youth-specific strategies to build relationships and trust with young people who have considerable complexity in their lives (for example, homelessness, unemployment and difficult personal and family circumstances). This complexity can make it difficult for them to connect with treatment, form therapeutic alliances and have continuity of care. To help remove barriers to treatment, mobile teams see young people where they are most comfortable, such as in their homes and temporary accommodation, schools and in outdoor areas such as parks.

For Youth Area Mental Health and Wellbeing Services that do not already provide mobile assertive outreach, they will build on existing models like the Intensive Mobile Youth Outreach Service (IMYOS) model. The IMYOS model has operated in Victoria since 1998.[165] The evidence base for IMYOS indicates that the following factors are essential for outreach to be successful:

- The clinicians and support workers can build strong therapeutic relationships with young people.[166]
- Treatment, care and support is focused at three levels—the young person, their family and the system of professionals involved in their care.[167]
- Teams often help the young person with their basic human needs such as food and housing in order to promote stability and recovery.

Research published in 2008 on the effectiveness of Orygen's IMYOS service found that among the 51 young people in the study, the IMYOS intervention 'seemed to have significantly reduced the number of clients requiring admission and the number of inpatient days compared with the previous nine months of office-based treatment'.[168] It also found that these young people were 'significantly less likely to contemplate suicide, to engage in self-harming behaviours and to be involved in violence and crime'.[169]

13.3.4 Redesigning bed-based services for young people

While the future system gives priority to community-based care, bed-based services remain an important part of the system. For a range of reasons (including their safety and the safety of others), a small number of young people require bed-based services to ensure they receive appropriate treatment, care and support.

Three reforms will strengthen bed-based services for young people:

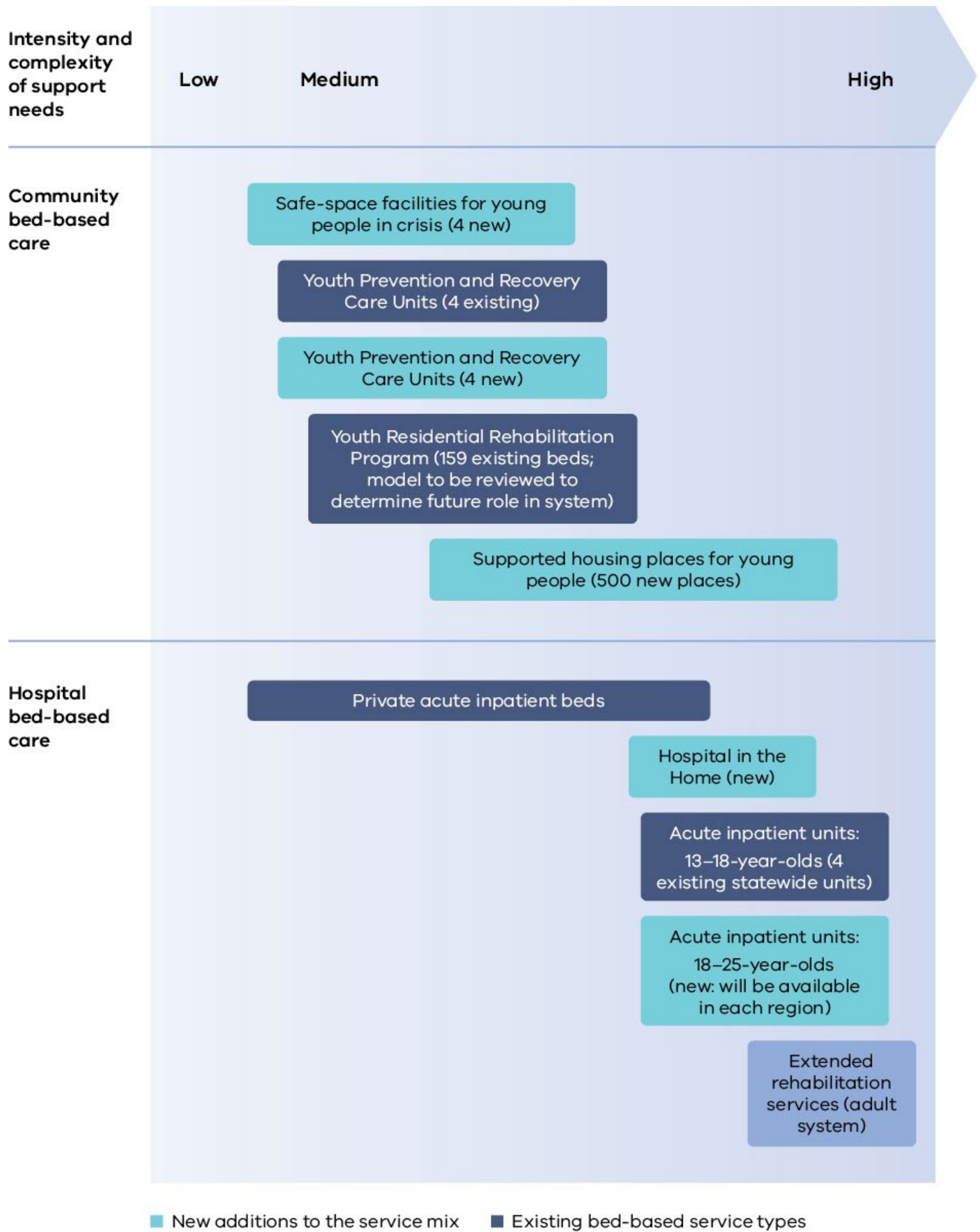
- a Youth Prevention and Recovery Care Unit in every region
- a review of youth residential rehabilitation facilities conducted in consultation with young people, families, carers and supporters
- a new youth acute inpatient stream, including Hospital in the Home as a substitute for an inpatient admission.

Key objectives of these reforms include:

- introducing more types of bed-based services to cater to young people who have the most complex and acute support needs—these settings will provide safe, supportive environments where young people can stabilise and focus on their recovery and wellbeing with 'step-up' and 'step-down' options that are between community-based care and an acute inpatient setting
- reducing the need for young people to be treated in acute inpatient beds—for the small number of young people where these settings are the best place to receive their treatment, care and support, establishing a youth acute inpatient beds stream for young people aged 18–25 years (this will ensure they are safe and that the care they receive is developmentally appropriate, therapeutic and recovery-oriented)
- enabling more young people to be treated closer to home, or preferably in their homes, where it is safe to do so
- reducing wait times for bed-based services.

The new continuum of bed-based care for young people in the future youth service stream is shown in Figure 13.12. While the figure shows the full range of bed-based reforms for young people, the reforms that relate to the safe-space facilities for young people in crisis are detailed in Chapter 9: *Crisis and emergency responses* and those that relate to supported housing are detailed in Chapter 16: *Supported housing for adults and young people*.

Figure 13.12: Continuum of bed-based care in the future youth service stream



A Youth Prevention and Recovery Care unit in every region

While young people and clinicians consistently spoke of the value of Youth Prevention and Recovery Care (Y-PARC) units, there was also evidence of limited and inequitable access to these units across Victoria.

Y-PARCs were first introduced in Victoria in 2012. One of the innovative features of Y-PARCs is that clinical services and wellbeing supports, as Y-PARCs are delivered through a partnership between mental health services and non-government wellbeing providers.[170]

Y-PARCS are currently the only subacute bed-based service in Victoria's youth mental health system. Victoria has three Y-PARCs: ten bed units in Bendigo (run by Bendigo Health's Mental Health Services in partnership with Mind Australia),[171] Frankston (run by Peninsula Health's Mental Health Service in partnership with Mind Australia and Mentis Assist)[172] and Dandenong (run by Monash Health's Mental Health Services in partnership with Mind Australia).[173] There was a fourth 20-bed Y-PARC funded in the 2018–19 State Budget.[174] Orygen Specialist Program will run this Y-PARC, which is under construction at Parkville with an estimated opening date in 2021.[175]

Y-PARCs offer voluntary, subacute, intervention and recovery-focused clinical and non-clinical treatment services in residential settings for up to 28 days for young people aged 16–25 years.[176] They are designed for young people who are:

- becoming unwell, or who are unwell but whose recovery progress has plateaued—these young people benefit from a brief intensive recovery support intervention (called step-up), or
- in the early stages of recovery from an acute phase of mental ill health and who need a time-limited period of additional support in order to strengthen gains made from spending time in an inpatient setting, which helps to consolidate their community transition and treatment plans (called step-down).[177]

Multiple clinicians and advocacy groups described the value of Y-PARCs, especially in regional areas, where access to acute inpatient beds is difficult and places young people at some distance from their families, carers and supporters. Dr John Cooper, Consultant Psychiatrist, Bendigo Child and Adolescent Mental Health Service, confirmed the importance of the Y-PARC model at the area level:

> **I am able to boast that we have a Y-PARC. And I think everybody–every area should have a Y-PARC. I think it's an excellent model that keeps kids out of hospital.**[178]

Similarly, in correspondence with the Commission, the Royal Australian and New Zealand College of Psychiatrists Victorian Branch indicated:

> **Members have suggested that Youth Prevention and Recovery Centres (Y-PARCs) should be considered further as a model for short-stay mental healthcare for young people.**[179]

The College identified the particular need for Y-PARCs in regional areas.[180]

The University of Melbourne published an independent evaluation of the Frankston Y-PARC in October 2017. The findings were positive. The evaluation covered 288 young people who used the Frankston Y-PARC between 2015–17, and concluded that:

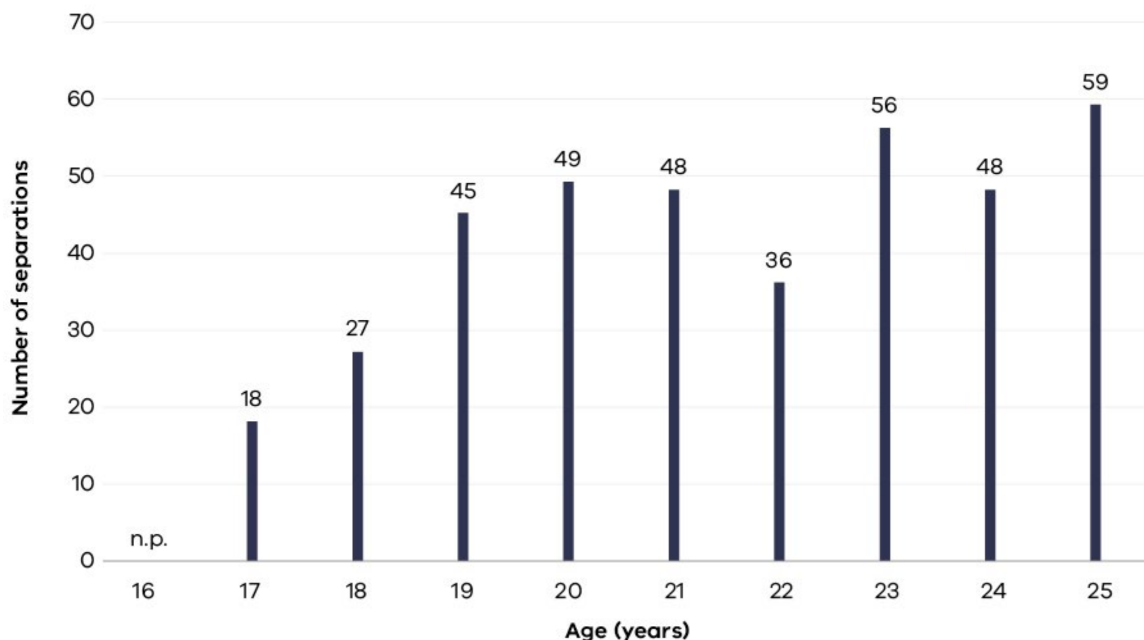
- There were good indications that the Y-PARC was contributing to clinical recovery due to the average decline in Health of the Nation Outcome Scales and Health of the Nation Outcome Scales for Children and Adolescents scores for young people after admission.
- There were encouraging indications that use of Peninsula Health's emergency department decreased after an admission to the Y-PARC.
- The exit survey and interviews indicated very high levels of satisfaction among young people, families, carers and supporters.
- Improved relationships between parents and the young person were reported as a result of a stay at the Y-PARC.
- Stakeholders provided extensive feedback on the contribution the Y-PARC made to the system. They reported how it filled a 'gap' between community services and acute inpatient mental health hospital wards.
- Family members and young people commonly contrasted the Y-PARC with hospital units. They spoke about how the service focused on long-term wellness, rather than merely medication and risk management.
- There were, however, significant gaps in responding to the substance use or addiction problems of consumers.[181]

As shown in Figure 13.13, due to the limited availability of Y-PARCs, young people aged 16–25 years are also admitted to adult Prevention and Recovery Care units. This results in young people being treated in the same facility as adults, with developmentally inappropriate adult models of care applied.

Y-PARCs have an important role in the future youth mental health and wellbeing service stream. More Y-PARCs should be available across Victoria, not just in the current four locations. To achieve this, in the future service stream, each of the eight regions will be funded to establish a Y-PARC to deliver step-up and step-down subacute 24/7 residential treatment, care and support to young people aged 16–25 years. Y-PARCs will be delivered through the partnerships of Infant, Child and Youth Area Mental Health and Wellbeing Services.

The Department of Health will work with Infant, Child and Youth Area Mental Health and Wellbeing Services to develop a consistent statewide model of care for Y-PARCs. This must be co-designed with young people, families, carers and supporters. This model of care should implement the recommendations from the evaluation of the Frankston Y-PARC, ensure that step-up, as well as step-down treatment, care and support can be provided, ensure that peer workers are valued as part of multidisciplinary teams and put in place arrangements to network all Y-PARCs so cycles-of-learning are embedded. For those four regions that already have a Y-PARC, funding may need to be increased and operational arrangements changed to deliver this model of care.

Figure 13.13: Number of separations for young people aged 16–25 to adult Prevention and Recovery Care services by age, Victoria, 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store, 2019–20.

Notes: This excludes admissions to Youth Prevention and Recovery Care services at Peninsula Health, Bendigo Health and Monash Health. Age is calculated based on date of admission.

n.p. indicates not published because of small numbers.

A review of youth residential rehabilitation facilities

Youth residential rehabilitation facilities are another type of bed-based service available to young people living with mental illness or experiencing psychological distress. They are designed to provide residential psychosocial rehabilitation for young people aged 16–25 years with a mental illness for a maximum of two years.[182]

Since 2014, there have been 17 multi-unit properties, providing accommodation and wellbeing support services for up to a total of 159 young people at a time, funded by the then Department of Health and Human Services.[183] There are currently seven non-government wellbeing providers contracted to deliver youth residential rehabilitation facilities across the state. In 2017–18, 112 consumers used a 24-hour youth residential rehabilitation facility, and 757 used a non-24-hour youth residential rehabilitation facility. [184]

The aim of youth residential rehabilitation facilities is to help young people to achieve their recovery goals. These may include:

> learning or relearning skills and gaining the confidence required for independent living
>
> learning to better manage their mental illness
>
> developing social relationships, social connections, recreation, physical health, education, vocational training, employment and housing, and other needs
>
> support for alcohol and drug issues.[185]

Ms Nicole Bartholomeusz, CEO, cohealth told of the impact of the Youth Residential Rehabilitation facilities:

> We have also seen good outcomes for our Youth Residential Rehabilitation services, which aim to help young people to achieve their recovery goals. This service was independently reviewed in 2017 and found that it is having a significant positive impact on the life domains of the young people … Across the program, more than 50% of young people have made a significant improvement in seven of the ten life domains (Managing Mental Health, Physical Health and Self-care, Living skills, Social Networks, Relationships, Responsibilities, and Identity and Self-esteem).[186]

There is considerable variation in the method of operation and models of care at each of the properties across Victoria. For example, some charge a small service fee to cover utilities, wi-fi access and some living expenses, while others do not, and the length of time a young person can stay varies between 12 and 24 months.

Two of the 18 properties are 24-hour services, with the remaining 16 properties non 24-hour services, which typically means that the young people are on site on their own overnight with a staff member available on call if needed. A lack of 24/7 support means that young people aged 16–25 years must be assessed as able to live in a group setting somewhat independently. The Commission understands that this can exclude young people with more complex support needs from using these services.

The Commission has outlined major reforms to youth mental health and wellbeing services, including to the type and parameters of bed-based services. Given these changes, the youth residential rehabilitation facilities should be formally reviewed to determine their future role in a redesigned youth mental health and wellbeing service stream. The outcomes of this review will ensure the model of care and service delivery arrangements for this program are contemporary, fit for purpose and deliver good outcomes for young people.

Case study:

Bendigo Youth Prevention and Recovery Care

Bendigo Health's Youth Prevention and Recovery Care (Bendigo Y-PARC) is a 10-bed facility that provides 24-hour treatment and support for young people aged 16–25 years.

The service is a short-term, recovery-focused residential facility for people who are either leaving acute mental health care as their risk profile has improved, or who would benefit from 24-hour support to avoid a hospital admission and can be safely managed in an open setting. The service functions as a short-term 'step up' (from community care) or 'step down' (from hospital) residential stay to either prevent further deterioration of someone's mental state or to further assist with their recovery, or both. In 2018–19, it provided care for 121 people.

Bendigo Y-PARC is part of Bendigo Mental Health Services, with wellbeing support programs subcontracted to Mind Australia. The multidisciplinary clinical team includes mental health nurses, occupational therapists and social workers, as well as psychiatrists and psychiatry registrars.

After an initial psychiatric assessment to establish the clinical treatment required, participants are supported for a period of up to 28 days to help develop healthy routines and take part in group programs focused on areas such as anger management, problem solving and daily living skills. Families are involved in the assessment and treatment plans whenever possible.

Dr John Cooper, Consultant Psychiatrist at the Youth Mental Health Service of Bendigo Health, said the facility was purpose built and started operating in 2013. It provides a more therapeutic atmosphere than a hospital environment, and aims to promote recovery and rehabilitation.

> It's very youth friendly, it's a comfortable inviting physical space. It's a combination of a clinical service provided through Bendigo Health, and we also work in partnership with Mind to deliver a range of psychosocial interventions such as income support, engagement with community programs, as well as helping people develop daily living skills, such as shopping, meal planning and cooking.

Dr Cooper added that 'step up' admissions can include re-admissions, both as a means of keeping young people safe and providing them with more support without requiring a hospital admission.

> An example of a step-up admission would be if a young person has achieved therapeutic goals in the community, for example, avoiding self-harm, staying off illicit drugs, or engaging in school or work but they then start to struggle and need more support, we would endeavour to provide a brief planned admission as an alternative to an inpatient unit.

Dr Cooper said because there are no inpatient hospital facilities in the area to accommodate young people under 18 years old, Bendigo Y-PARC gives those between 16 and 18 the option to avoid travelling to Melbourne for help if they can be managed safely.

> We help avoid some of those admissions that would otherwise happen. YPARC is about keeping people out of hospital and providing an individualised approach, with all the benefits a multidisciplinary team can provide.

Nikayla, a patient at Bendigo Y-PARC, said the service helped her in many ways and helped her 'enjoy the little things in life again'.

> Y-PARC helped me find my old self. It helped me get through the victims of crime stuff with the support of the clinicians and Mind staff. I feel like there should be more of this on offer for everyone and that it should be more well-known, I did not know things like this existed until I came here.

Source: RCVMHS, *Interview with John Cooper*, October 2020.

This review, to be conducted in consultation with young people, families, carers and supporters, will consider:

- the future role in the mental health and wellbeing system for youth residential rehabilitation services, including in the context of the reforms to community care units described in Chapter 10: *Adult bed-based services and alternatives*
- opportunities for shared governance between clinical mental health services and non-government providers that provide wellbeing supports
- potential changes to intake and vacancy management functions, including all properties providing 24/7 on-site support
- strategies to ensure young people are discharged into stable housing and ongoing recovery-oriented supports (noting that the 500 new supported housing places for young people, described in Chapter 16: *Supported housing for adults and young people*, will assist with this).

A new youth acute inpatient stream

Chapter 10: *Adult bed-based services and alternatives* articulates the need for, and purpose of, acute inpatient mental health beds in Victoria's future mental health and wellbeing system. This need was reinforced by youth mental health clinicians, including Associate Professor Radovini who gave evidence that:

> I think there will be an ongoing need for some inpatient units and it's usually around what I would call complexity; when you bring together issues of safety, issues of sometimes diagnostic clarifications, lack of support, comorbidity[187] and the need to kind of provide a safe environment and tease apart some of the things that are unclear, and time to bring the supports in place, is how I would see inpatient units being able to be used.[188]

In line with lifting the age at which young people transition to adult mental health and wellbeing services to 25 years (on their 26th birthday), the Commission is introducing a new youth stream of acute inpatient beds in each of the eight regions. This will ensure young people aged 18–25 years are no longer admitted to adult acute inpatient beds. This new stream for young people aged 18–25 years will be operated by Infant, Child and Youth Area Mental Health and Wellbeing Services.

These beds will complement the existing acute inpatient beds for young people aged 13–18 years. These are provided by four child and adolescent mental health services or child and youth mental health services on a statewide basis, according to defined geographic areas. These beds are provided by the Royal Children's Hospital, Monash Health, Austin Health and Eastern Health.[189] If an expansion to acute inpatient beds for this age group is needed at a future point, it should occur initially through the introduction of Hospital in the Home. Further, the six beds currently allocated for this age group across three regional health services (two at each of the three regional services)[190] should either cease to operate or be converted to adult beds where they have been operating as part of a larger adult ward. The Commission considers that these beds do not provide sufficient scale to ensure high-quality treatment, care and support for young people. This is in line with the directions in Chapter 10: *Adult bed-based services and alternatives*, which indicates that acute inpatient facilities need to be of adequate scale to ensure safety and effectiveness.

The creation of a new stream of acute inpatient beds for young people aged 18–25 is a major reform. At present, through Melbourne Health, Orygen Specialist Program is the only child and youth mental health service that operates acute inpatient services exclusively for young people aged 16–25, with an inpatient unit located at Western Health's Footscray Hospital site (16 beds) plus additional private beds contracted through Wyndham Clinic Private Hospital.[191] Across all eight regions, a significant reconfiguration of existing beds in the adult mental health and wellbeing system and the opening of new beds (and potentially new builds to house the new streams) will be required.

The introduction of the new stream responds to the concerns of young people, families and clinicians about the potentially detrimental and traumatic impacts on young people when they are treated in adult acute inpatient beds. One young person shared with the Commission:

> When I was younger, I remember I was admitted to an adult ward because there were no youth beds. It was really scary, particularly as I was put in high dependency. Once I woke up in the middle of the night because this man was stroking my face.[192]
>
> In the adult system, I struggled a bit because the peer workers were older than me and I could not relate to them. I also found that in adult inpatient units, although some have groups, they're very far and few between.[193]

One family shared experiences of their daughter being treated in an adult inpatient ward:

> When Thea has been admitted into an adult psychiatric unit, she tends to hide in her room. She won't often go out into the common areas. She's physically scared of some of the other patients. There are often people in these units who are yelling and screaming out, and Thea doesn't do that sort of thing so it frightens her.[194]

Orygen also highlighted concerns about this:

> Inpatient care is particularly concerning with young people placed in wards with adults or with individuals who can be experiencing specific mental health conditions and symptom severity that can be confronting, distressing or remove a sense of hope for many young people for whom this is their first inpatient admission and experience of a severe episode of poor mental health. In this system, young patients fail to engage and exit care resulting in poor outcomes and dangerous consequences.[195]

Many young people aged 18–25 years are admitted to adult acute inpatient beds each year. Commission analysis shown in Table 13.2 indicates that in 2019–20 this number was 2,334. This equates to 112 beds or 14.9 per cent of the total available funded beds in adult mental health services.

Table 13.2: Number of young people aged 18–25 years admitted to acute adult mental health beds, Victoria, 2019–20

Health service	Total clients aged 18–25 years admitted to an adult acute bed	Estimated equivalent number of acute adult beds occupied by clients aged 18–25 years	Estimated proportion of total acute adult beds occupied by clients aged 18–25 years
Albury Wodonga Health	48	3	20.0%
Alfred Health	154	7	13.0%
Austin Health	68	3	15.8%
Ballarat Health Services	74	3	13.0%
Barwon Health	115	4	14.3%
Bendigo Health	127	5	14.3%
Eastern Health	263	12	14.3%
Goulburn Valley Health	58	3	20.0%
Latrobe Regional Hospital	130	4	13.8%
Melbourne Health (excl. Orygen)	459	19	13.1%
Mercy Health	210	14	18.7%
Mildura Base Hospital	43	1	10.0%
Monash Health	507	23	17.6%
Peninsula Health	85	3	10.3%
South West Healthcare	40	1	6.7%
St Vincent's Hospital Melbourne	119	7	15.9%
Total	2,334	112	14.9%

Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

Notes: The total equivalent acute beds occupied by consumers aged 18–25 years who separated in 2019–20 was calculated by using the total length of stay of the consumers and a bed occupancy target of 90 per cent.

Admissions to Orygen's acute youth beds and Adult PAPU beds have been excluded from this analysis.

The Department of Health will work with Regional Mental Health and Wellbeing Boards to determine how best to implement a new youth acute inpatient stream in each region. This will include a combination of strategies, including repurposing existing beds being used for people aged 26 years and over and the opening of new beds, as a subset of the recommended 100 new beds set out in Chapter 10: *Adult bed-based services and alternatives*. In each region, this will require careful consideration of a range of factors, including:

- which of the Infant, Child and Youth Area Mental Health and Wellbeing Services have the best capability to operate an acute bed-based service
- the logistics associated with reconfiguring beds currently in use in the adult mental health and wellbeing system as quickly as possible and with minimal disruption
- increasing equity of access to bed-based services for young people who live regionally and rurally
- a process to co-design the new youth acute inpatient stream with young people.

Clear referral pathways into the new streams in each region will also need to be developed, as well as productive working relationships established between the referral services and the Infant, Child and Youth Area Mental Health and Wellbeing Service operating the new stream.

To ensure the youth acute inpatient stream in each region has its own culture and model of care that is distinct from adult inpatient models, the Department of Health will oversee development of a new statewide model of care for youth acute inpatient services. This will consider the most developmentally appropriate therapeutic interventions and wellbeing supports, as well as the introduction of youth and family peer workers on wards. This new model of care should be developed in partnership with young people, families, carers and supporters and Youth Area Mental Health and Wellbeing Services.

The development of the statewide model of care will draw on research with young people regarding their experiences in inpatient care. For example, a study seeking young people's perspectives on mental health inpatient care suggested that the support of peers was frequently regarded as one of the most helpful aspects of hospitalisation, as were group therapy and the opportunity for 'time out'.[196] This model of care should be in place by the end of 2022, with arrangements for providing the new stream agreed in each region and youth acute inpatient wards starting to open.

In line with Chapter 10: *Adult bed-based services and alternatives*, and as recommended in the Commission's interim report, Hospital in the Home should also be available as a direct substitute for an acute inpatient admission. Where it is safe to do so, Hospital in the Home provides hospital-level treatment, care and support in the patient's own bed, rather than a hospital bed, with the person remaining an admitted patient. While Hospital in the Home facilitates treatment, care and support being provided in young people's homes, it remains the equivalent of a hospital-based service.

Personal story:

Elvis Martin

Elvis came to Australia as an international student and was admitted to an inpatient unit after a suicide attempt when he was 18.

> I think I hated myself. When I woke up in emergency after [attempting suicide] I was like, 'I failed in this as well'.

He said he spent months in a youth-specific inpatient unit, whereas other consumers were gone after a few weeks. He enjoyed the inpatient unit's dedicated sensory room and says that experiencing the humanity of the mental health workforce was helpful for his recovery.

> Good psychologists always took it on a journey of basic things ... and want to know more from me, and my feelings and things like that. The bad psychologists that I've had, they want to know little from me, and they want to tell me more how wrong I am.

Elvis has also spent time in an adult inpatient unit.

> I was in an adult inpatient unit for a short time, that is again scary. As a young person in an adult inpatient unit, it's very difficult because sometimes people are coming up with very challenging mental health situations, and they are in a very difficult space, and they need more help. And that is scary if you have never witnessed that before.

He reflected that there was not much for him to do while in the unit.

> There are not many activities that young people like, there's no painting, colouring or things like that. Small activities that keeps us young people engaged. It's more of a hospital space. I would say, you just take medicine, you sit there, you don't do much, or you might walk around, you might do this and that, but it's not engaging.

Elvis did not feel that being a young person in an adult inpatient unit helped his recovery.

> I wouldn't really call that recovery model helpful for young people because it does not involve many activities and things that can help young people's recovery. The recovery of an adult experiencing mental health is very different to the recovery of a young person.

He hopes that the Royal Commission will make a difference for future generations.

> What we have right now is much better than any other country, I would say. But [it's] still not working completely. So we still need to acknowledge that. Yes, we are doing good … but there is a way to go.

Source: RCVMHS, *Interview with Elvis Martin*, November 2020.

While the introduction of Hospital in the Home will allow more young people to stay in their homes and communities, for a range of reasons, for some young people it might not be safe or appropriate.[197] Some young people may also prefer to receive their treatment, care and support in a hospital environment and the decision to offer Hospital in the Home must be informed by the young person's preferences.[198]

The preference of the young person's family, carers and supporters should also be considered, with the Commission hearing from some families that Hospital in the Home may not be an appropriate, or preferred, option for them.[199]

Introducing Hospital in the Home for young people should draw on the lessons from existing services across Australia. In Perth, an eight-bed youth model of Hospital in the Home is available for young people aged 16–24 years.[200] An independent evaluation of 430 admissions to this service from 1 March 2017 to 21 January 2020 suggested positive results. On admission, average scores on the Health of the Nation Outcome Scales were in the 'moderately severe' range. On average, there was a 41.5 per cent drop in scores between admission and discharge, indicating significant improvements in wellbeing.[201] Further, in its interim report, the Commission recommended that Orygen be provided with funding to deliver 15 youth mental health beds across north-western Melbourne under the Hospital in the Home model.[202]

Chapter 10: *Adult bed-based services and alternatives* also outlines that no Area Mental Health and Wellbeing Service should operate acute inpatient beds in another area's service. To ensure this new policy is followed, the Department of Health will need to consider the future operation of Orygen's Inpatient Unit, located at Western Health's Footscray Hospital site.[203] In 2019–20, there were 322 people that received treatment, care and support in Orygen's Inpatient Unit.[204] Approximately 95 per cent of those admissions were young people aged 18–25 years.[205]

The reforms to the youth mental health and wellbeing service stream are major and will require change at many levels including the structural, system, service, individual and cultural levels. As the reforms have been guided by the voices of young people, system leaders and clinicians, the strong support required to take these reforms forward already exists and should be harnessed.

Getting some of these reforms off the ground will rely on implementing the Commission's broader reform agenda, such as establishing the Regional Mental Health and Wellbeing Boards and the various legislative changes required. The availability of the right funding, workforce (including training and entry-level positions) and infrastructure is also an important implementation factor.

As discussed in more detail in Chapter 37: *Implementation*, the implementation of the Commission's reform agenda will be staged over a 10-year timeframe, with three waves of reform (short, medium and long term). Many of the reforms outlined in this chapter will be implemented within the short-term wave.

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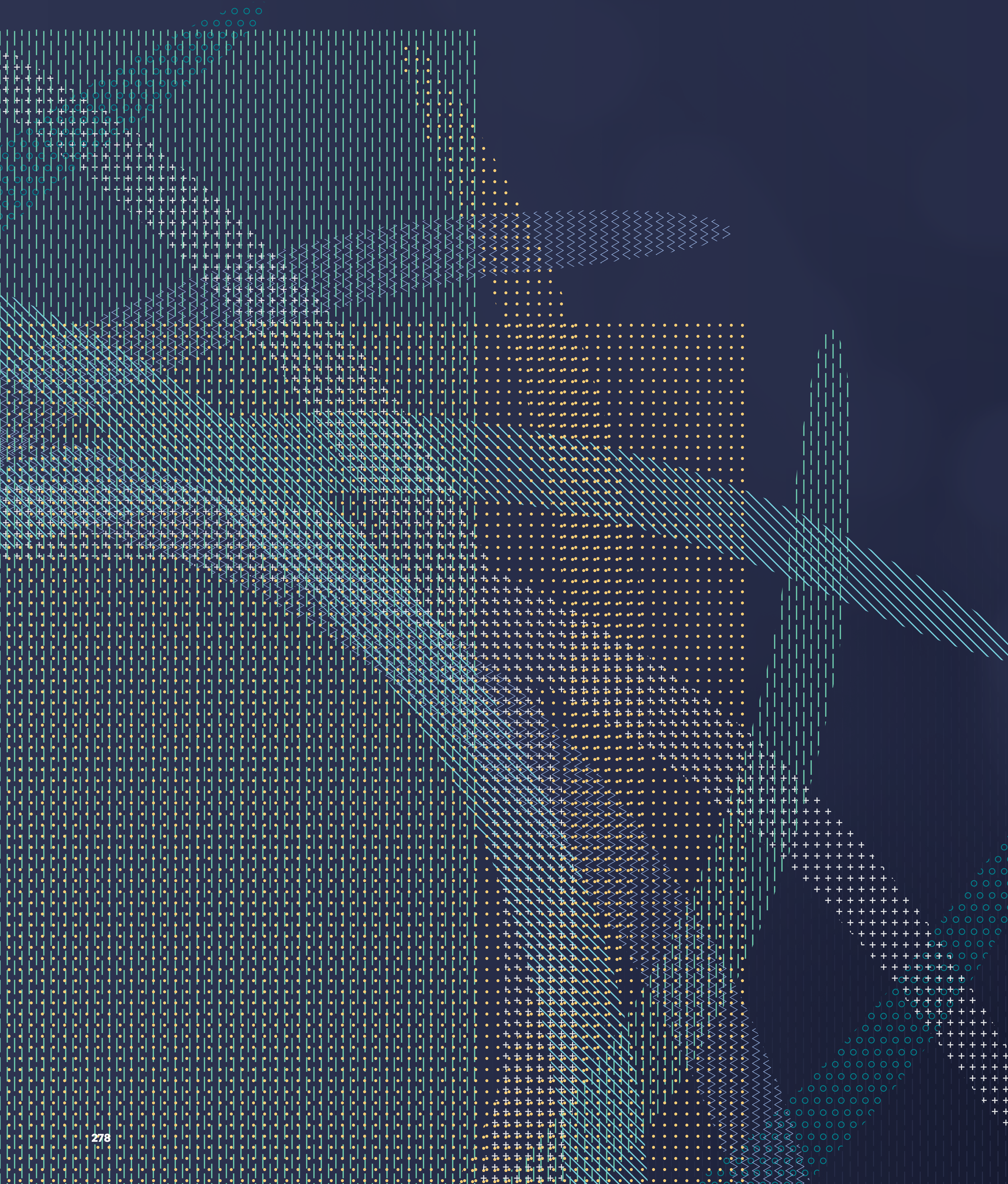


Chapter 14

Supporting the mental health and wellbeing of older people

Recommendation 22:

Supporting the mental health and wellbeing of older Victorians

The Royal Commission recommends that the Victorian Government:

1. establish a responsive and integrated mental health and wellbeing service stream for older Victorians, that focuses on improving their mental health and wellbeing outcomes.
2. ensure older Victorians have access to the same mental health treatment, care and support as the rest of the adult population.
3. establish older adult mental health and wellbeing specialist multidisciplinary teams in Adult and Older Adult Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b)), to:

    a. provide specialist mental health treatment, care and support for people with complex and compounding mental health needs generally related to ageing; and
    b. assist primary and secondary care and related services that support older Victorians, including aged care, through primary consultation, secondary consultation and shared care.

14.1 The mental health and wellbeing of older Victorians

The Commission's letters patent identify the need to 'recognise and respect the needs of different population groups and communities including … older Victorians'.[1]

The existing mental health system and many other relevant systems across Australia, such as the Commonwealth's aged care system and the National Disability Insurance Scheme generally define older Victorians as any person residing in Victoria who is aged 65 years or older. As this chapter outlines, the Commission considers an age boundary of 65 years of age useful for the purposes of system planning but problematic as an access criterion for mental health and wellbeing services.

'Older Victorians' describes a diverse population group, with varied and changing mental health support needs. However, older Victorians may experience developmental changes that generally occur later in life that affect the mental health treatment, care and support they may require.

14.1.1 An ageing population

Older Victorians make up a significant, and increasing, proportion of the population. In Victoria, approximately 16 per cent of the population is aged 65 years or older.[2]

Consistent with global trends, Victoria's population is ageing (that is, an increasing proportion of the population is older) due to declining fertility rates and increased life expectancy.[3] Over the next three decades, the number of Victorians aged 65 years or older is estimated to double, rising from 1.05 million (as of 30 June 2020) to 2.13 million by 30 June 2051.[4] This will reflect an overall increase from 16 to more than 20 per cent of the Victorian population.[5]

As the population ages, Victoria is also likely to see an increase in the number of older Victorians living with mental illness.[6]

14.1.2 Mental health and wellbeing later in life

The Commission recognises the inherent value of each older Victorian, and respects and appreciates the role of older Victorians in society.

Older Victorians contribute to society in diverse and meaningful ways. They raise families, support neighbours, work and contribute to their local communities as volunteers (formally and informally).[7] Older Victorians often play a role in supporting and caring for people with poor mental health (in particular, partners, adult children and grandchildren).[8] In Victoria's Aboriginal communities, Elders are honoured for their efforts to advocate for the self-determination and wellbeing of their communities that experience continued adversity and systemic racism.[9]

The characteristics of the older Victorian cohort are also changing. Developments in the medical world over the past century mean that people are now living longer and more independent lives,[10] in 'better health than ever before.'[11]

Not only are older Victorians experiencing higher and longer quality of life, but communities are benefiting from their ongoing contributions.[12]

Older Victorians need to be served equitably and effectively by the future mental and wellbeing health system. This is particularly the case for two different groups of older Victorians who will access the future mental health and wellbeing system. The first is those who have lived for some portion of their lives with ongoing mental illness, and where ageing may play a greater or lesser role in their mental health. The second is those who develop mental illness in their older years, where those challenges are generally related to, or compounded by, ageing.

14.1.3 Diverse and changing needs

While the Commission refers to older Victorians as one population group, this cohort comprises people whose needs and characteristics vary considerably.

Everyone experiences ageing differently, based on factors such as life experiences and physical health.[13] While some older Victorians may still be employed, active and independent, others may be retired, experiencing declining physical mobility and becoming more dependent on family and friends for support. Many older Victorians act as carers for their loved ones and some live alone; others live in residential aged care facilities.

Some groups of people may also be more likely to experience ageing at a faster rate than the broader older Victorian population. For example, people who experience homelessness may be at higher risk than the general population of 'early dementia and accelerated ageing'.[14] One study found that 'dementia prevalence amongst Indigenous Australians is almost five times the rate as that in the general population and that it presents at an earlier age'.[15] In recognition of the way that these groups experience ageing, the Commonwealth has adjusted its approach to funding aged care services; for example, it has lower eligibility thresholds for Aboriginal people and those experiencing homelessness.[16] It also funds residential facilities such as Wintringham, which supports people aged 50–65 years of age who experience homelessness.[17]

Further, a large proportion—just over one-third—of Victoria's older population is culturally diverse, and approximately 27 per cent were born in non–English speaking countries.[18] Over the past decade, migration to Victoria has increased the diversity of the population.[19] It is not known, however, whether the COVID-19 pandemic will have an effect on this trend. Regardless, it will be important for the future Victorian mental health and wellbeing system to provide treatment, care and support in ways that cater to the diverse needs of this cohort.

People with culturally diverse backgrounds can experience 'language regression' as they age (particularly those with dementia), where even those with strong English skills can revert back to their language of birth.[20] This can pose a barrier to people's ability to access, and then their experience of, Victoria's mental health services. In the future system, it will be critical for mental health and wellbeing services—at local, area and statewide levels—to be designed and delivered in a way that is accessible to culturally diverse older people.

Ro Allen, Victorian Commissioner for Gender and Sexuality (now known as the Commissioner for LGBTIQ+ Communities), also told the Commission that older LGBTIQ+ people can experience particular mental health challenges—including a higher risk of suicide—due to the personal challenges (for example, family rejection, increased stigma and discrimination, and grief and loss particularly related to HIV and AIDS) that this cohort can experience.[21] Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* provides detail on the Commission's proposed approach to working with diverse communities.

14.1.4 Characteristics of older adulthood

While everyone experiences ageing differently, older adulthood is generally characterised by a number of social and developmental changes such as:

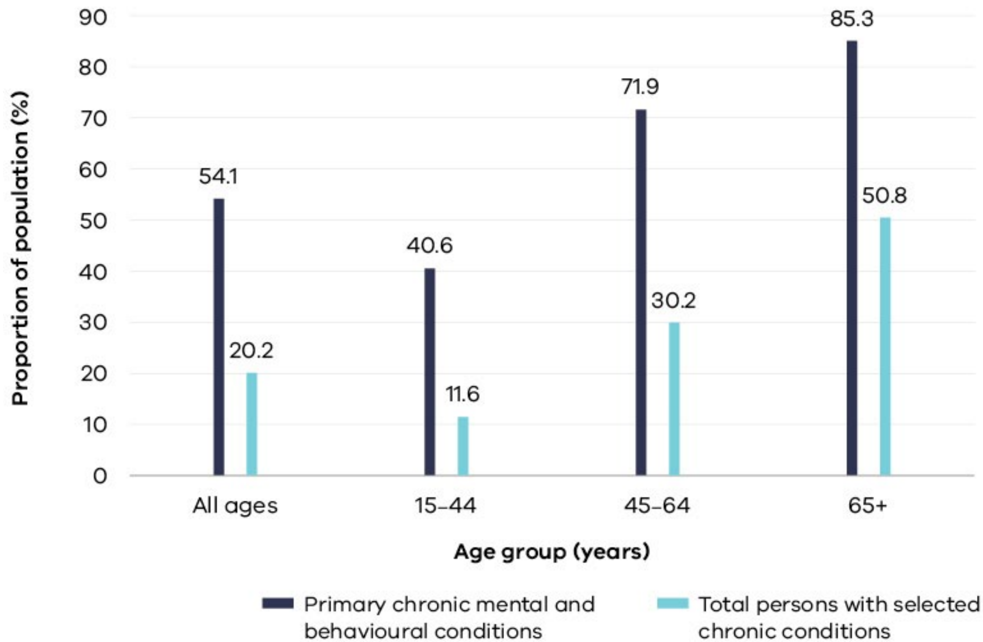
- retirement and the associated loss of an income and valued social role
- the loss of loved ones
- the loss of physical health and independence.

These changes can cause feelings of loss and grief, increased psychological distress, increased social isolation and loneliness.[22] As Ms Georgie Harman, CEO of Beyond Blue, told the Commission, '[t]he physical and social changes that come with ageing can leave older people vulnerable to poor mental health.'[23]

People experience these changes in different ways, and at different points in time. It is also important to recognise that some of these changes—particularly retirement—provide opportunities for people to take on different roles and life experiences.

Older Victorians also experience higher rates of co-occurring physical and mental health conditions than the rest of the adult population. As shown in Figure 14.1, more than 85 per cent of people aged 65 years or older who reported a mental health and behavioural condition as a primary chronic condition also experienced other chronic conditions.[24] This compares with 51 per cent of the total population aged 65 years or older who reported any chronic conditions (irrespective of whether or not they had a mental illness).[25]

Figure 14.1: Proportion of Australians with multiple selected chronic conditions, by mental health status and age groups (years), Australia, 2017–18



Source: Australian Bureau of Statistics, National Health Survey: First Results, 2017–18—Australia, Table 19.3.

Notes: Selected chronic condition include arthritis, asthma, back problems (dorsopathies), cancer (malignant neoplasms), chronic obstructive pulmonary disease, diabetes mellitus, heart, stroke and vascular disease, kidney disease, mental and behavioural conditions and osteoporosis. Proportion includes persons who have a current medical condition that has lasted, or is expected to last, for six months or more; except for persons reporting diabetes mellitus and/or heart, stroke and vascular disease, which are included irrespective of whether the condition is current and/or long term. Multiple conditions belonging to the same condition type (for example, mental and behavioural conditions) are treated as the one condition. For example, a person with anxiety and depression (and no other chronic condition) is treated as having one selected chronic condition.

These social and developmental changes can complicate the identification of, and treatment, care and support for, mental illness or psychological distress in older Victorians.[26] For example, the increasing incidence of dementia can complicate the identification of mental illness and psychological distress in older Victorians due to the similarities in the symptoms of both conditions.[27] As described by the National Mental Health Commission, dementia and other health issues can make it more difficult to identify mental health issues:

> **Age-related health conditions such as frailty and dementia can mask the symptoms of mental illness, with the result that mental illness may go undiagnosed and untreated.[28]**

14.1.5 Increased risk of social isolation and loneliness

The changes that occur during this stage of life can also increase the risk of older Victorians experiencing social isolation and loneliness. While there is a lack of consensus on whether older Victorians are more likely to experience social isolation and loneliness than other age groups, it is generally accepted that loneliness can be influenced by periods of adjustment following significant changes in a person's life (such as retirement, the loss of a driver's licence, or the loss of a loved one).[29]

Strong social networks and the ability to sustain quality relationships and social contact are important protective factors against social isolation and loneliness.[30] As Gerard Mansour, Commissioner for Senior Victorians, identified in his 2016 report:

> A sense of connectedness to local communities, and of belonging to others, is an important antidote to loneliness for many older people … a feeling of disconnection from community, and of feeling like a stranger or an outsider, is associated with loneliness.[31]

Research indicates that social isolation and loneliness can be a risk factor for mental and physical health issues.[32] A recently published study found that the majority of participants who reported higher levels of loneliness also reported increased depressive symptoms.[33] As Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London, stated to the Commission in a personal capacity:

> social isolation in older people is deadly—it kills. But before social isolation kills an older person, it harms their mental health.[34]

Further discussion on the issue of social isolation and loneliness and the Commission's recommendation to connect older Victorians with their local communities through social prescribing can be found in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

14.2 Current challenges with treatment, care and support for older Victorians

The Commission identified a number of issues and challenges that older Victorians face, which are relevant both to their experiences of the existing mental health system and considerations for the future system.

14.2.1 Aged persons mental health services

In the existing Victorian mental health system, aged persons mental health services are responsible for delivering mental health services to people aged 65 years or older. This includes those experiencing mental illness who have grown older, and those who develop mental illness later in life.[35]

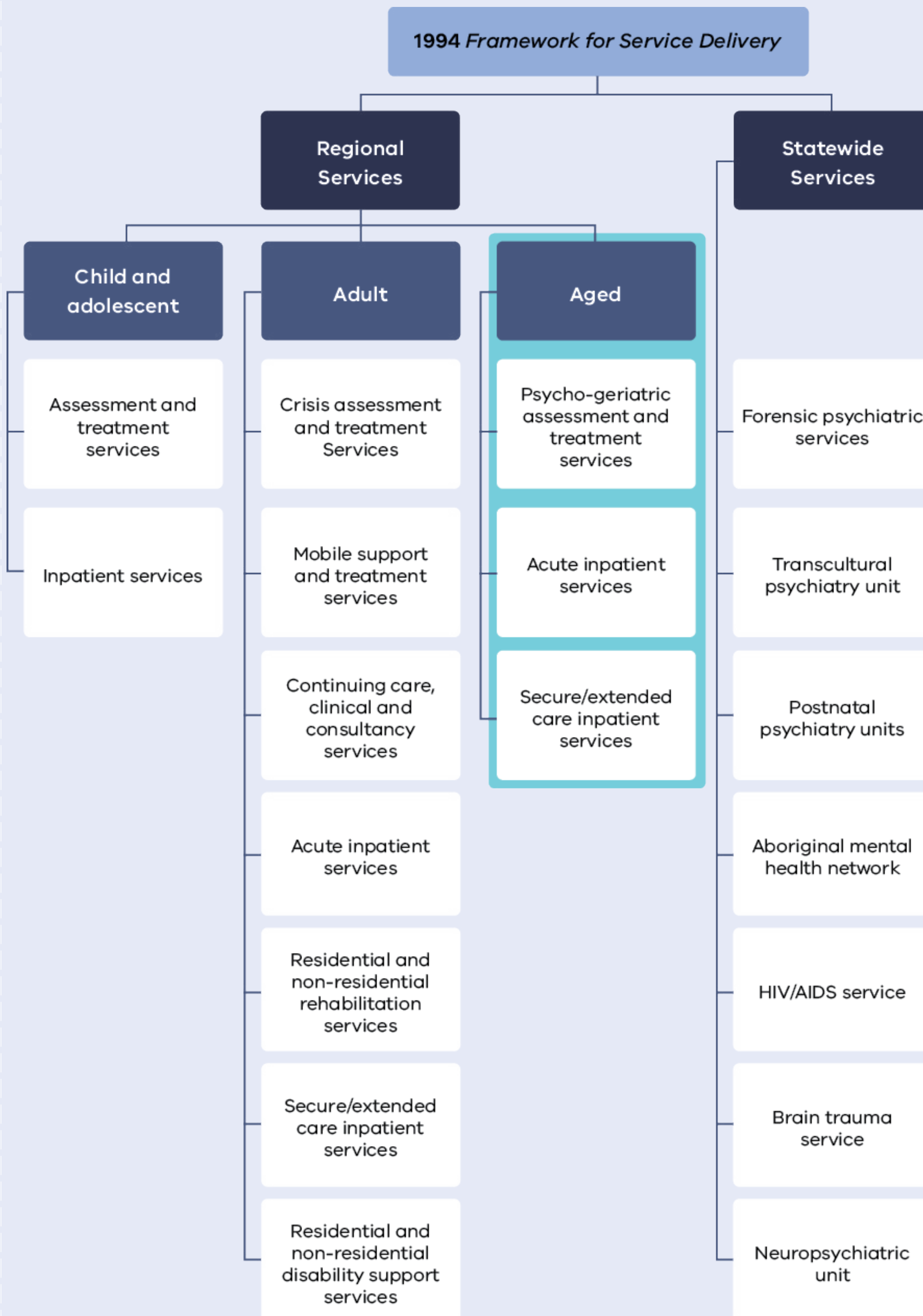
The current system design follows the *Framework for Service Delivery* developed in 1994 by the former Victorian Department of Health and Community Services.. As shown in Figure 14.2, the framework identified the mental health services that would be delivered on a regional basis and a statewide basis and grouped regional services by three age categories: child and adolescent, adult and aged.[36] Under this model, aged persons mental health services were responsible for delivering three types of services: community-based assessment and treatment services, acute inpatient services and extended care inpatient (or residential aged care) services.

An overview of these three service types is provided below:

- 'Psycho-geriatric assessment and treatment services' (also referred to as community assessment and treatment services) provide community-based assessment, treatment, rehabilitation and case management for older Victorians.
- 'Acute inpatient services' provide short-term inpatient management and treatment for people requiring acute treatment, care and support until sufficient recovery allows the person to be treated effectively in the community.
- 'Secure/extended care inpatient services' (also referred to as specialist public sector residential aged care services) provide a range of specialist bed-based services to consumers who cannot be supported in mainstream aged care residential services due to the complexity and intensity of their support needs. These services provide longer term accommodation, ongoing assessment, treatment and rehabilitation.[37]

While the 1994 framework stated that aged persons mental health services were responsible for supporting people aged 65 years or older, it also specified that this age boundary should be applied with some level of flexibility to cater for individual needs.[38] As discussed below, due to limited resources and high demand pressures, service providers have often been unable to apply this in practice.

Figure 14.2: The 1994 *Framework for Service Delivery* and establishment of aged persons mental health services



Source: Department of Health and Community Services, *Victoria's Mental Health Service: The Framework for Service Delivery*, 1994, p. 14.

14.2.2 A system under pressure and access challenges for consumers

As identified in the interim report, Victoria's mental health system has been overlooked, with resources directed towards other areas of health and government. This has created a service gap, where many people are not able to access the treatment, care and support they need. Older Victorians are particularly affected by this gap, as aged persons mental health services have been considered a low priority within Victoria's mental health system. The Commission heard that, in this environment of increasing demand and resourcing pressures, Victoria's mental health system is 'rejecting' older Victorians.[39]

Within a neglected mental health system, aged persons mental health services have been further neglected, with priority generally being given to area mental health services that support young people or adults. Figure 14.4 shows that between 46 and 55 per cent of the older Victorians in 2019–20 who required specialist mental health services did not receive those services (compared with 18 to 41 per cent of people aged 0–25 years and 32 to 46 per cent of people aged 26–64 years). Further, demand for specialist mental health services has grown for Victorians aged 65 years or older as shown in Figure 14.3. This figure examines the number of people who needed specialist mental health care compared with the Commission's estimate of those who accessed care through public and private systems.

The Commission estimates that in 2019-20, 35,000 older Victorians had a level of need for specialist mental health services equivalent to the three highest intensity consumer streams described in Chapter 6: *The pillars of the new service system–community-based mental health and wellbeing services*. They are the short-term treatment, care and support stream, the ongoing treatment, care and support stream and the ongoing intensive treatment, care and support stream.

As shown in Figure 14.3, of those 35,000 people, Victoria's current public specialist mental health services saw only 9,767 (27.9 per cent).

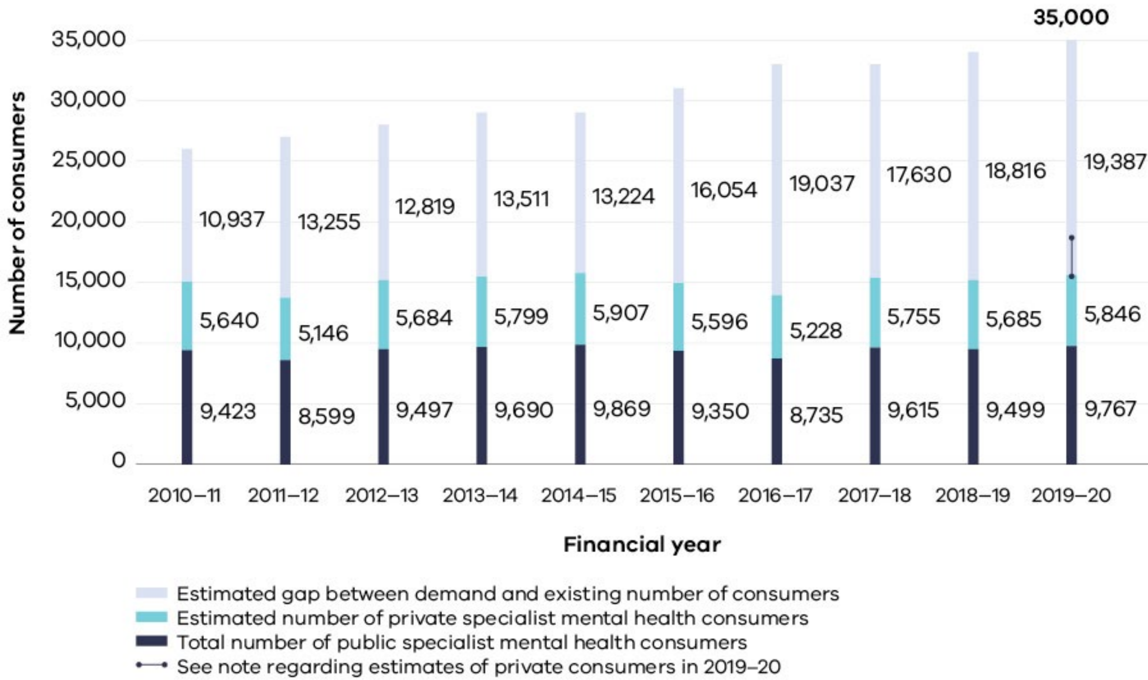
Of those 35,000 people, a further estimated 5,846 people (16.7 per cent) to 9,026 people (25.8 per cent) accessed specialist mental health services in the private health system in 2019–20. Private specialist mental health services might include mental health services provided in a private hospital or multiple Medicare-subsidised psychiatric services (refer to Figure 14.3). Such private services are not accessible to all—for example, those with lower incomes or those in areas with limited private sector supply.

Figure 14.3 also shows the specialist service gap for older Victorians—the proportion of those 35,000 people in 2019–20 who were estimated to require services who did not get them in either the public or private systems. This service gap was estimated to be between 16,207 people (46.3 per cent) and 19,387 people (55.4 per cent). The second part of the figure shows that in 2019–20 public specialist mental health services delivered only 142,000 (20.1 per cent) of the estimated 705,000 hours of care required by older Victorians.

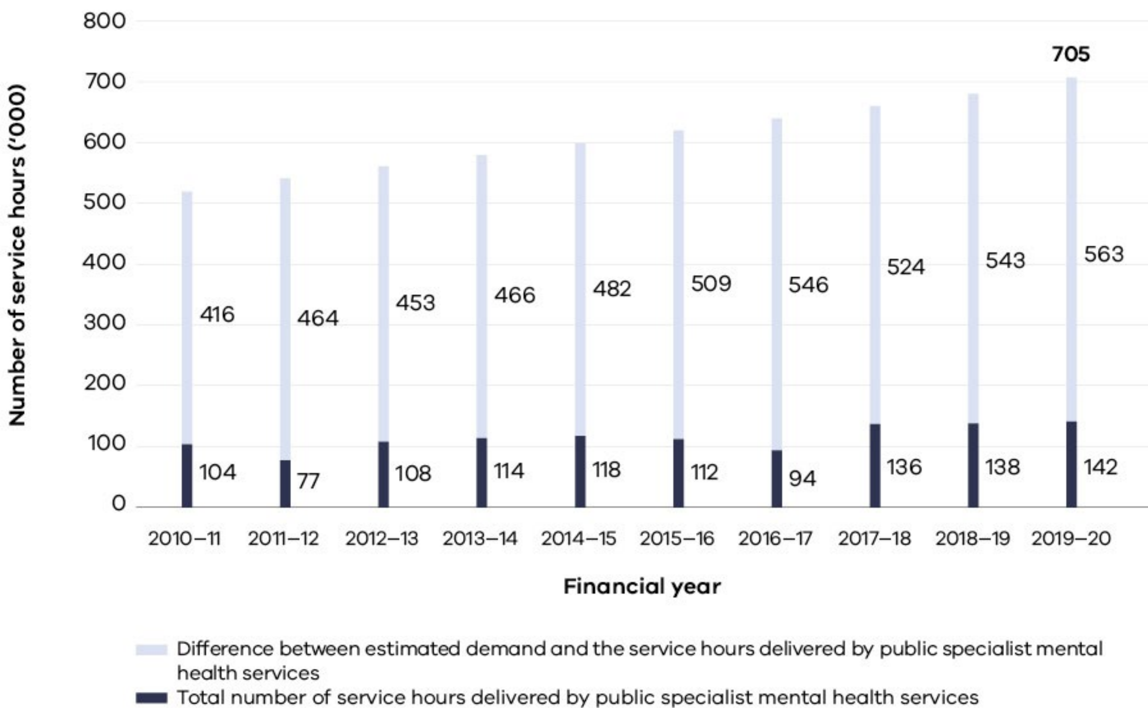
This measure of unmet demand emphasises substantial gaps in the comprehensiveness of specialist mental health care delivered, even for those consumers who do access services. This data does not include the gaps in access to wellbeing supports.

Figure 14.3: The difference between the actual number of people receiving specialist mental health services/actual consumer-related community service hours delivered and estimated demand, 65+ years, Victoria, 2010–11 to 2019–20

A. Consumers



B. Service hours



Sources: A. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2018–19; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18; Australian Institute of Health and Welfare, *Mental Health Services in Australia: Medicare Subsidised Mental Health-Related Services 2018–19*. Table MBS.2.

B. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

A. The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology. This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store, which in 2019–20 was 16 per cent of total contacts.

For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers in 2019–20. First, 5,846 consumers, which would mean there is an estimated gap of 19,387. This estimate is based on the proportion of people that had a mental health admission to a private hospital only. Second, 9,026, which would mean there is an estimated gap of 16,207. This includes all people that received more than one service from a Medicare-subsidised psychiatrist or had a mental health–related admission to a private hospital. Anyone also received public specialist mental health services have been excluded to avoid double counting.

B. Some of the gap may be met through services delivered in the private mental health system. Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity, for example assessment, monitoring, and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

This increase in demand for aged persons mental health services has been a trend over the past decade and is accompanied by a reduction in per capita investment in service provision.[40] Data indicates that the Victorian Government's per capita expenditure on aged persons mental health services has declined, while expenditure on services for other age cohorts has generally increased (refer to Figure 14.5).

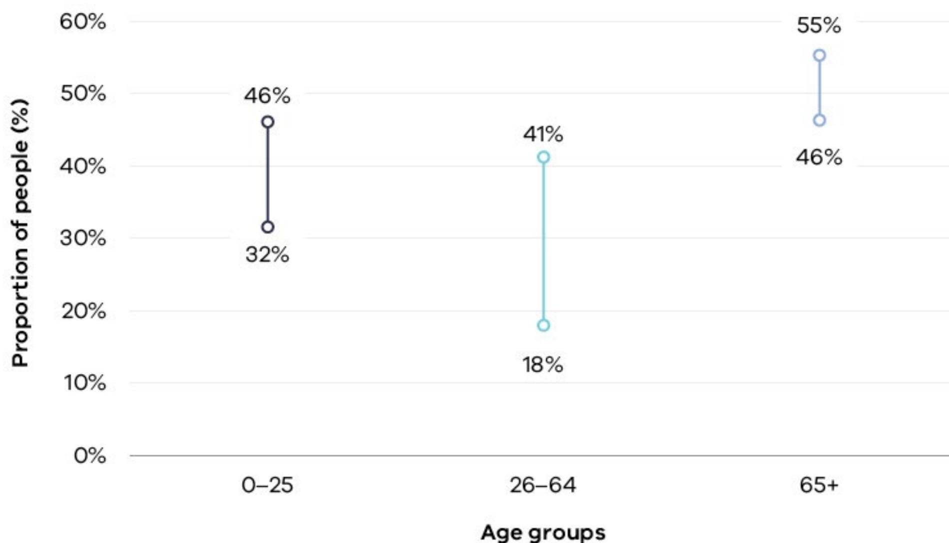
This is a pressing issue for Victoria. As one older Victorian stated:

> **There is a lack of forward planning in the light of our ageing population. There will be much more demand for aged persons mental health services.**[41]

The Commission was told that increasing demand and continued under-investment are forcing aged persons mental health services to establish high eligibility thresholds (that is, criteria for being eligible to receive services).[42] In the Commission's expert roundtable, participants said that this climate has caused aged persons mental health services to become 'a place of last resort'.[43]

In their joint submission to the Commission, Mental Health Victoria and the Council on the Ageing Victoria highlighted this issue and described how the significant levels of unmet demand have led to aged persons mental health services being 'rationed and strictly targeted to people with severe mental health conditions, particularly those with long-standing conditions'.[44]

Figure 14.4: Estimated proportion of consumers who required specialist mental health services but did not receive those services from the public or private systems, by age groups (years), Victoria, 2019–20



Sources: Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2019–20; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18; Australian Institute of Health and Welfare, *Mental Health Services in Australia: Medicare Subsidised Mental Health-Related Services 2018–19*. Table MBS.2

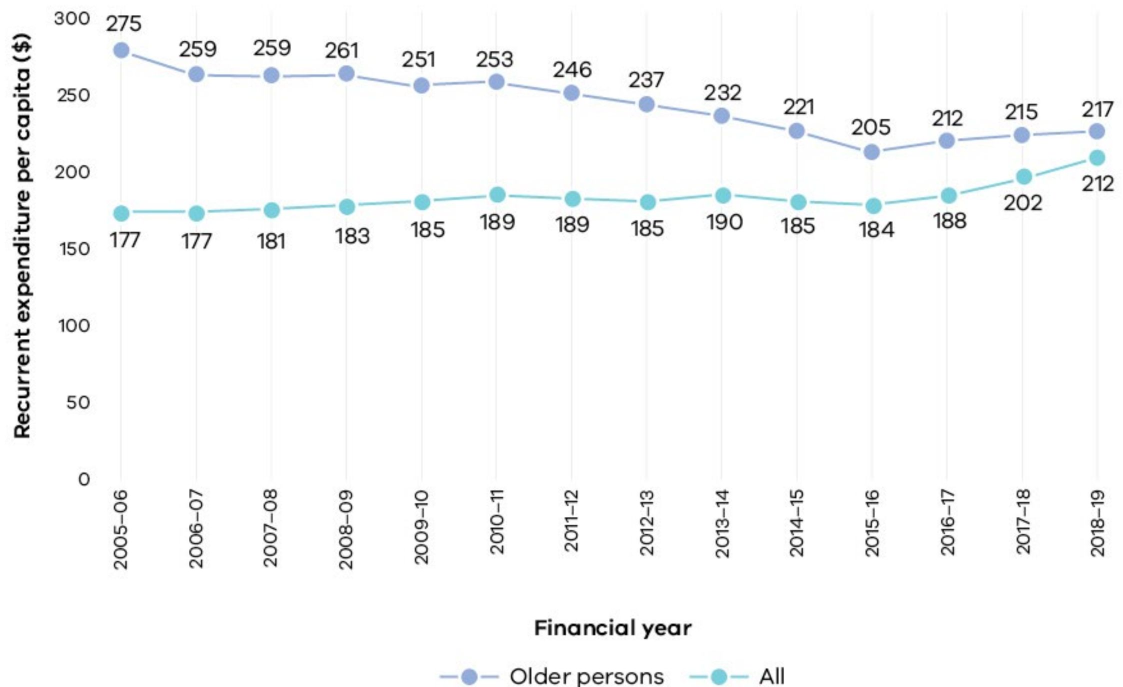
Notes: The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology.

This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store, which in 2019–20 was 16 per cent of total contacts.

Two alternative estimates of the number of private specialist mental health consumers are included, which lead to two estimates of the proportion of consumers who require but did not receive specialist mental health services.

First, it is estimated that 46 per cent (0–25-year-olds), 41 per cent (26–64-year-olds) and 55 per cent (65 years or older) of consumers in each age group respectively required but did not receive specialist mental health services. These estimates are based on the proportion of people that had a mental health admission to a private hospital. Second, it is estimated 32 per cent (0–25-year-olds), 18 per cent (26–64-year-olds) and 46 per cent (65 years or older) of consumers in each age group required but did not receive specialist mental health services. This includes all people that received more than one service from a Medicare-subsidised psychiatrist or had a mental health–related admission to a private hospital. Anyone who also received specialist mental health services was excluded to avoid double counting.

Figure 14.5: Recurrent expenditure per capita ($) on specialised mental healthcare services, constant prices, by target population, Victoria, 2005–06 to 2018–19



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Expenditure on Mental Health Services 2018–19, Table EXP.12 <www.aihw.gov.au/reports/mental-health-services/ mental-health-services-in-australia report-contents/summary-of-mental-health-services-in-australia>, [accessed 29 January 2021].

Notes: Collections and counting rules may have changed over the reporting period. Data reported based on mental health unit type.

Consumers also identified this as an issue, describing how a system that is so short on resources is affecting people's ability to receive services:

> You have to hit rock bottom before services are offered.[45]
>
> This is an impending issue, with several of my peers turning 65, and … the under-funding of aged care mental health will leave many in distress and at-risk.[46]

Demand pressures may have also led to a more rigid application of the age boundary, with adult services seeking to refer consumers to aged persons mental health services wherever possible—even when they may be better suited to the adult system. As Mr Daniel O'Connor, Deputy Chief Psychiatrist (Aged), in the former Victorian Department of Health and Human Services, told the Commission, this can mean people are rejected from service providers:

> [There] is just a constant pressure from hugely … stretched and under-resourced adult mental health services to push people in their 50s onwards, who have cognitive impairment as part of their psychosis, [or] bipolar disorder, to aged mental health services … it's unfair and is rejecting of people.[47]

The rigid application of the age boundary results in people being excluded from accessing or receiving the range of services that are available in the adult system. A number of older Victorians identified this as an issue for their treatment, care and support:

> My needs don't suddenly change when I turn 65.[48]
>
> My access to care and support should not be so dramatically affected by a birthday. From the time I have turned 65, I have gradually lost access to the support and care that I need and used to enjoy.[49]

In their joint submission, Mental Health Victoria and the Council on the Ageing Victoria pointed to the inequity of the current arrangements:

> [We] believe that older Victorians are important, contributing members of the community who have the same rights and needs for programs and services across the continuum of mental health promotion, illness prevention, treatment, recovery support and suicide prevention as other age groups. At present, they are missing out in many of these areas ...[50]

14.2.3 Stigma and discrimination

Older Victorians experience stigma and discrimination relating to both their age and mental health challenges. Evidence suggests that older Australians are often subject to ageist beliefs and stereotypes that do not accurately reflect the nature of this cohort.[51]

There are concerns that ageism may be driving the poor prioritisation of resources for older Victorians.[52] For example, the Council on the Ageing Australia asserted that:

> the matter of ageist attitudes is a systemic problem that exists across the broader health sector. This also appears to be reflected in government policy, with a recent analysis revealing that the needs of older people with mental illness are not reflected in existing policy solutions and priority actions.[53]

Health professionals may also fail to identify mental illness or psychological distress in older Victorians because they attribute relevant behaviours as being normal parts of the ageing process.[54] As one roundtable participant told the Commission, 'growing old does not mean growing mentally ill'.[55] This stigma and discrimination may be affecting older Victorians' access to treatment, care and support.

Mental health professionals may also be influenced by ageist misconceptions and stereotypes. For example, the results of one survey completed by 707 psychologists and counsellors across Australia suggested that these mental health professionals may have held ageist views towards older clients.[56] Each survey sent out included a case study, which involved either a 42-year-old-client or a 72-year-old client. The case studies sent out were identical, with the exception of the age.

The survey asked a series of questions about the person in the case study and found:

> The older client was rated as significantly less able to develop an adequate therapeutic relationship, to have a poorer prognosis, and to be less appropriate for therapy; and the therapists felt less competent in treating her and were less willing to accept her as a client.[57]

Ageism may also be preventing older Victorians from seeking help or engaging with mental health services. As the National Ageing Research Institute stated to the Commission, ageism can result in older Victorians feeling less motivated to engage in healthy behaviours, meaning they impose limitations on their own wellbeing (that is, internalising stigma).[58] Research also indicates that older Victorians who consider declining mental health to be a normal part of ageing are less likely than young adults to seek help or engage with mental health services.[59] The Council on the Ageing Victoria also raised this as an issue:

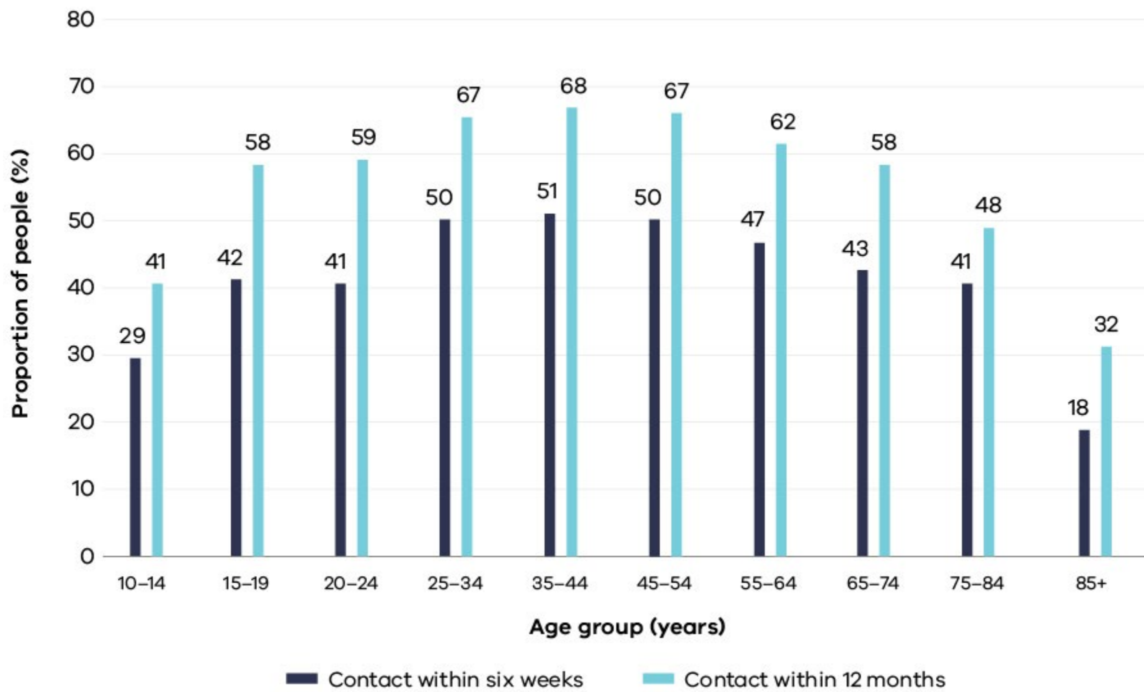
> A number of older people with mental illness spoke about the sense of stigma and shame they felt when first seeking help. Participants also spoke about the relationship between stigma and self-medication; with some disclosing that people will often turn to drugs or alcohol as a coping mechanism so they can avoid the stigma associated with seeking support.[60]

The Commission heard that this is an issue for older men in particular because they are not as likely to express mental health concerns to anyone, including their own families.[61] This may be contributing to the high rates of suicide that older men experience—nationally men aged 85 years or older experience the highest rates of death by suicide compared with other age groups.[62]

The Coroners Court of Victoria's analysis of the Victorian Suicide Register also suggests that older Victorians who ultimately die by suicide may be less likely than other age groups to have engaged with a health service for a mental health-related reason in the year before their death, as shown in Figure 14.6.[63]

As described in Chapter 17: *Collaboration for suicide prevention and response*, the Commission is recommending a range of suicide prevention and response initiatives that build on the interim report's recommended expansion of follow-up care and support for people after a suicide attempt. Many of these initiatives will be available for older Victorians. The Commission is also recommending the development of a new suicide prevention and response strategy for Victoria that will consider where initiatives should be tailored or designed to the needs and interests of particular cohorts, including older Victorians.

Figure 14.6: Proportion of people who died by suicide who had contact with health services for mental health-related reasons within six weeks and 12 months of suicide, Victoria, 2009 to 2016



Source: Coroners Court of Victoria, Suicide and Mental Ill Health in Metropolitan Melbourne and Regional Victoria: Data Update Prepared For The Royal Commission into Victoria's Mental Health System, 2020.

14.2.4 The need for early intervention and prevention

The Commission was told that the Victorian Government appears to focus less on early intervention and prevention for older Victorians than other age groups. In the words of one older Victorian, '[c]ompared to the youth system, there is less of a prevention and early intervention focus in aged persons mental health.'[64]

The Commissioner for Senior Victorians also emphasised this need, highlighting how the concept of early intervention and prevention remains important for those later in life:

> **There is often an oversight when thinking about prevention that it only involves those of a young age. Someone who is just turning 60 years of age will on average still have about 25 years of life left to live. The concept of prevention remains relevant for aged persons mental health.**[65]

Early intervention and prevention strategies can:

- prevent and address social isolation and loneliness
- normalise help-seeking behaviour and reduce the stigma and discrimination surrounding mental illness and psychological distress
- increase awareness of the signs and symptoms to look out for to support older Victorians and the community more broadly to recognise mental illness and psychological distress
- raise awareness of the various mental health and wellbeing services and supports that are available.[66]

There are a number of existing initiatives—such as the University of the Third Age, men's sheds and neighbourhood houses—that give older Victorians a way to build social connection and prevent social isolation and loneliness.[67] These community-based supports may also be used to increase awareness of and reduce the stigma surrounding mental illness in older Victorians, as illustrated through the story of one older Victorian.

The Commission was told, however, that older Victorians may often be unaware that these supports are available and may be hesitant to attend the service due to a lack of confidence or stigma.[68]

The Commission recognises that physical health conditions such as the loss of hearing or vision—as was the experience in William's personal story—can contribute to, or exacerbate, poor mental health. For example, Deaf Victoria told the Commission that people experiencing deafness may be at increased risk of suicide due to the increased likelihood that they will experience social isolation, physical health problems and self-reported poor quality of life.[69]

Personal story:

William

William* is 79 years old and experiences depression and anxiety. He also has late-onset vision impairment. William attributes his long-term problems with alcohol as the most likely reason for his three suicide attempts.

After William's first suicide attempt, he found the support limited. He explained he was referred to a mental health unit where he says he 'sat in the waiting room for an hour and walked out when no one came out to see me'. After another attempt a few years ago, William's GP referred him to his local aged persons mental health service.

> As soon as the referral went through, the mental health nurse came and visited me at my house and we had a chat and made an appointment to see the psychiatrist and the other private psychologist that I see. I got a regular appointment at the clinic and I saw both the psychiatrist and mental health nurse there every three or four weeks.

Following the retirement of both the mental health nurse and psychiatrist at the service, William now sees a new mental health nurse. William understands the service is trying to replace the psychiatrist but because he lives in a regional area, he says he thinks this may be difficult. However, William feels positive about recent progress in his treatment with his private psychologist.

> I'm working with my psychologist at present, where for the first time we've actually started talking about self-esteem. I am now starting to realise that throughout my life my self-esteem has never been great. I'm looking forward to keeping on working down that line.

William said his vision impairment has significantly affected his independence and his mental health. He feels it is important to hear experiences specific to your own, so you can see that other people are going through similar experiences.

> I listened to a talk on this on the internet from an ophthalmologist and it was the best information I have ever been able to obtain for my particular mental health problem because it was someone talking about low vision and mental health.
>
> It is helpful to hear other people were going through it and you're not on your own. And not on your own because your eyesight's failing, because you know you're not on your own there, but knowing you're not on your own when your eyesight is affecting your mental health.

Living in a regional area and no longer being able to drive makes accessing support services, particularly specialised support services, challenging for William.

When he sought mental health support specific to those with vision impairment from a vision support organisation, he was told it was only available in Melbourne or over the phone. William said he doesn't feel comfortable speaking about his mental health over the phone and has therefore not been able to use the service. The COVID-19 pandemic has also meant he has been unable to get support for the challenges he experiences with alcohol, which he hopes to do in the future.

William hopes sharing his story will help others. He feels strongly about the importance of education about mental health. He belongs to his local men's shed and organises the guest speakers for monthly events, where he often focuses on mental health topics to raise awareness. William would like to see better education in the broader community for recognising mental health issues and seeking support.

> We need to educate people and their families to know when they have got a mental health problem and when to go and seek help about it, rather than just sort of soldiering on and getting further and further into depression.

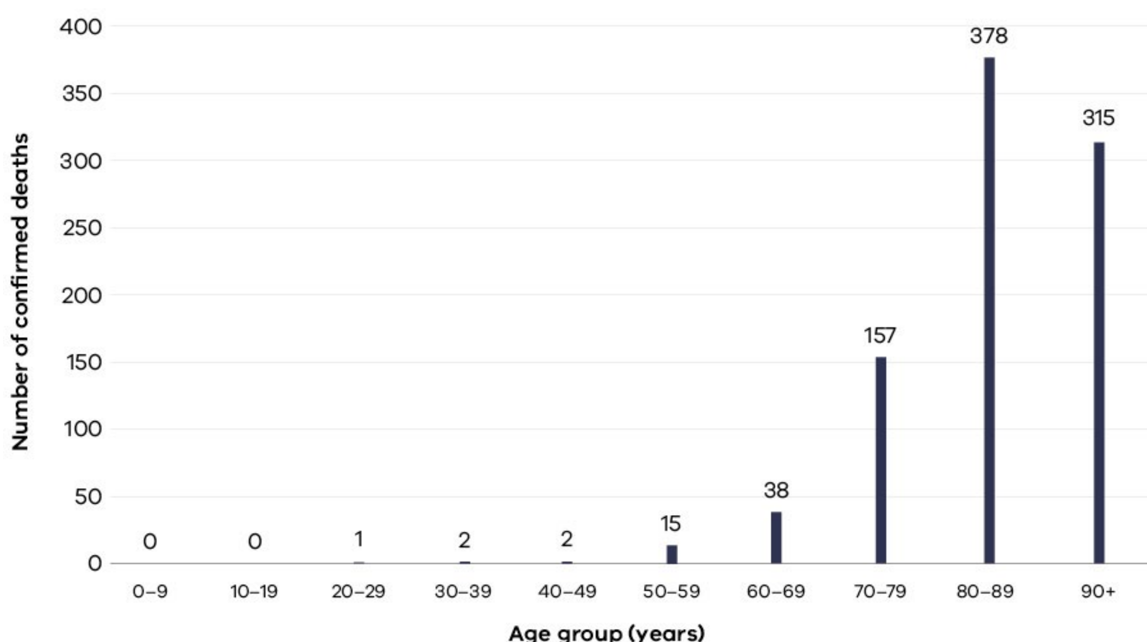
Source: RCVMHS, *Interview with 'William' (pseudonym)*, September 2020.

Note: * Name has been changed to protect privacy.

14.2.5 Disproportionate impacts of COVID-19

Sadly, older Victorians have experienced some of the worst impacts of the COVID-19 pandemic. In fact, the overwhelming majority of Australians who have lost their lives to COVID-19 to date are older. As shown in Figure 14.7, the majority of deaths have been among people aged 70 years or older. Of these cases, most were living in Commonwealth-funded residential aged care facilities in Victoria.[70]

Figure 14.7: COVID-19 deaths by age group, Australia



Source: Commission calculation of Department of Health (Commonwealth), Coronavirus (COVID-19) current situation and case numbers, <www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers>, [accessed 4 November 2020].

Notes: Total number of COVID-19-associated deaths in Australia by age group since 22 January 2020. As per the COVID-19 national guidelines, a COVID-19 death is defined for surveillance purposes as a death in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (such as trauma).

National Notifiable Diseases Surveillance System data as at 10 December 2020. Figures may differ from Australian Bureau of Statistics mortality statistics.

While this group was already at risk of experiencing social isolation and loneliness, the stay at home directions issued in response to the pandemic may have increased this risk.[71] Many of the traditional ways in which older Victorians engage with their communities and maintain social connection, such as through exercise and social activities, face-to-face business interactions and volunteering, were suspended.[72] While the rest of the population has moved to digital platforms for day-to-day activities such as working, communicating with friends and family, and shopping, many older Victorians have been left behind.[73]

> **Inadvertently, the COVID-19 safety guidelines to self-isolate have created new health risks by leaving many older adults even more socially isolated and inactive than before.[74]**

There is a risk that the COVID-19 pandemic, and the associated social distancing and lockdown measures, may lead to a decline in the mental health of older Victorians living in the community and in residential aged care settings.[75]

14.2.6 Concerns about acute inpatient units

Under the existing system, aged persons mental health services' acute inpatient units provide short-term bed-based services to support a person's recovery during the acute phase of mental illness. There are currently 237 funded aged mental health beds (174 metropolitan and 63 rural) across Victoria.[76] The Commission received evidence from consumers that raises concerns around safety, the quality of care provided and the use of restrictive practices in these facilities. This is discussed in Chapter 31: *Reducing seclusion and restraint*.

Some older Victorians told the Commission about their experiences feeling unsafe in these facilities:

> I feel I'm unsafe, lonely, isolated and trapped in inpatient centres. The environment is off putting.[77]
>
> It was scary … I will never trust the hospitals I was at again. They are terrifying places.[78]

Evidence from some older Victorians reflected on heavy use of medication within mental health service settings:

> I've been medicated so heavily that I once collapsed to the floor. The staff came over and gave me a kick, saying 'get up'. I said, 'I can't get up!' They said I was lying, 'yes you can'. This won't be in the notes, but I swear to you that it is true.[79]
>
> In 2016 I was taken to a psychiatric unit for elderly people for the first time for four weeks. It was horrible there. I felt like I was humiliated and tortured by people … And the medication, it was horrible. I was put on Risperidone [a form of antipsychotic medication] against my will and had to stay on high doses of that for quite some time. This was based on the wrong diagnosis and the wrong information about me. For instance, they diagnosed me with schizophrenia rather than PTSD [post-traumatic stress disorder].[80]

There is a concern that professionals and service providers tend to over-prescribe psychotropic medications (antidepressants and other medications that affect people's emotions and behaviours) for older Victorians. This issue was identified by the Royal Commission into Aged Care Quality and Safety in its interim report, particularly in relation to older Victorians in residential aged care settings.[81] It found that one of the 'major quality and safety issues' was:

> [The] widespread overprescribing, often without clear consent, of drugs which sedate residents, rendering them drowsy and unresponsive to visiting family and removing their ability to interact with people ...[82]

Research also indicates a need to better regulate the use of physical, mechanical and chemical restraints in mental health and aged care settings.[83] The Commission considers that defining and regulating the use of chemical restraint under the new Mental Health and Wellbeing Act will protect consumers and enable this practice to be appropriately monitored. This Commission's work on restrictive practices explores the issue of chemical restraint in mental health service delivery further in Chapter 31: *Reducing seclusion and restraint*.

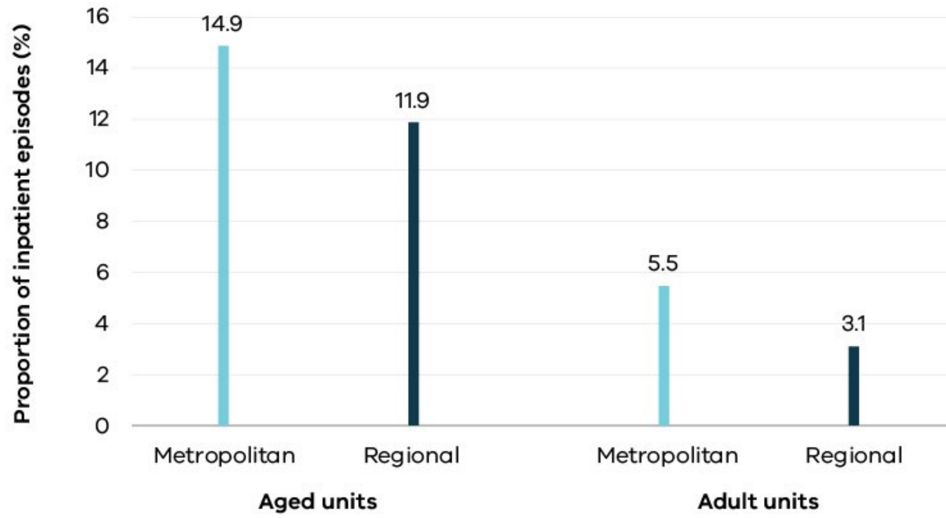
The existing physical infrastructure across the aged inpatient units poses additional challenges, with most facilities not having been updated or replaced since their establishment in the 1990s. As one older Victorian explained:

> The lived environment of aged care mental health units ... are exceedingly outdated and reflect the de-prioritisation of aged mental health—it feels as if the mental health system is forgetting people, letting them grow old and mentally decay ...[84]

Unlike adult acute inpatient units, six of the aged acute inpatient units in metropolitan Melbourne are not currently located at acute hospital sites (approximately 120 beds in total) but are instead located with residential aged care services.[85] The Commission's data analysis, presented in Figure 14.8, indicates that consumers who have been admitted to aged acute inpatient units in metropolitan Melbourne are more likely to be transferred to an emergency department or another hospital (an acute hospital site) during their stay.

This suggests that approximately one in every seven people admitted to an aged acute inpatient unit located in metropolitan Melbourne is transferred to an emergency department or another hospital during their stay. Given the majority of aged acute inpatient units in metropolitan Melbourne are not currently located at acute hospital sites, and older Victorians experience higher rates of physical health comorbidities than other age groups, the Commission considers that the Victorian Government should review the placement and configuration of these facilities.

Figure 14.8: Proportion of inpatient episodes that included a transfer to an emergency department or another hospital, by unit type, Victoria, 2009–10 to 2018–19



Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2009–10 to 2018–19.

14.3 Intersections with the Commonwealth's aged care and healthcare systems

In supporting the mental health of older Victorians, Victoria's mental health system intersects with the Commonwealth's primary and aged care systems. The vast majority of older Victorians will receive mental health treatment, care and support through the primary care system (including their GP). In addition, many older Victorians will access private specialist mental health care in the community subsidised by the Medicare Benefits Schedule. Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* provides detail on the role of primary and secondary mental health and related services in Victoria's future mental health and wellbeing system.

The Commission has determined that it is necessary to clarify how the Victorian mental health system and the Commonwealth aged care system intersect, to provide greater role clarity for government, service providers, older Victorians and their families, carers and supporters.

On 16 September 2015, the Commonwealth and Victorian governments signed the *Transitioning Responsibilities for Aged Care and Disability Services in Victoria* agreement. Under this agreement, responsibility for delivering 'services for older people' transitioned from the Victorian Government to the Commonwealth Government.[86]

Under the Commonwealth aged care system, in accordance with the *Aged Care Act 1997* (Cth), there are three types of support available to older Australians:

- home care—packages of personal care and assistance provided to people in the community who require support to maintain independence and remain within their own home[87]
- residential care—personal and/or nursing care to people in residential aged care facilities for those who are no longer able to remain in their own home; this includes 'appropriate staffing to meet the nursing and personal care needs of the person'[88]
- flexible care—alternative supports provided in residential or community settings, such as carer respite, short-term transition services, and so on.[89]

The Commonwealth aged care system is significantly larger than the Victorian mental health system. In 2018–19 the Commonwealth's aged care services in Victoria received approximately $5.26 billion in funding, while Victoria's mental health services received approximately $3.35 billion.[90] It is important to note that this funding for aged care services primarily supports people aged 65 years or older, while the funding for mental health services covers people of all ages. Of the funding for Victoria's public specialist mental health services, the Commission estimates that approximately $218 million was provided to aged persons mental health services in 2018–19.[91]

In addition to the interface with the Commonwealth aged care system, there is an important interface with the acute healthcare system when older Victorians are admitted to hospital for a physical condition. This affects older Victorians who have lived with ongoing mental health issues during their earlier adult life and those who experience mental health issues for the first time in older age—including those whose mental health issues are connected to the physical illness they are admitted for.

As outlined in Chapter 10: *Adult bed-based services and alternatives*, in-hospital consultation liaison services for mental health need reform. These services are generally neither adequately funded nor sufficiently and consistently integrated into the care teams in general health services. In the future system, there will be greater integration of mental health care in general health services. This will be particularly important for supporting the mental health and wellbeing of older Victorians. As shown in Figure 14.9, people are more likely to be admitted to public hospitals for physical health reasons as they age. For example, the first part of Figure 14.9 indicates that despite people aged 70–90 years of age making up a smaller proportion of the Victorian population, they have the highest rate of hospital use. Figure 14.9 also shows that older Victorians are generally less likely to be admitted to public hospitals for mental health reasons than younger age groups.

It will also be important for the Victorian Government to consider the interface between the future mental health and wellbeing system and the National Disability Insurance Scheme. Currently, National Disability Insurance Scheme participants who turn 65 have the choice to remain in the National Disability Insurance Scheme or transition to the aged care system. Given the large-scale reform currently underway in both the aged care and disability sectors, the Victorian Government will need to consider these changes as it implements the Commission's reform agenda.

The Commission anticipates that the aged care and disability sectors will undergo major transformation, as evidenced by the two commissions currently underway. As the Royal Commission into Aged Care Quality and Safety's Commissioners described in their interim report, titled 'Neglect':

> This cruel and harmful system must be changed. We owe it to our parents, our grandparents, our friends. We owe it to strangers. We owe it to future generations. Older people deserve so much more.[92]

The Chair of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability also emphasised the need to transform the disability sector:

> The Royal Commission … heard in public hearings and community forums many harrowing accounts of violence, abuse, neglect and exploitation of people with disability … the Royal Commission provides a genuine opportunity to bring about the transformational changes necessary to achieve a more inclusive society.[93]

Personal story:

Tina

Tina* is 68 years old and cares for her sister, Faye*, who is 71 years old and has been diagnosed with schizophrenia.

> **In my family and our tradition, my mum always told me, 'you have to look after your sister'.**

Tina also cares for her husband, who suffers from a severe depressive illness. Tina talked about the challenges that they have had accessing and receiving support from both the aged care system and the Victorian mental health system.

Tina and her sister emigrated from China, and following her marriage breakdown, Faye started to experience a decline in her mental health. At the time, she was receiving some support in the adult mental health system and in-home support from a community-based non-government organisation. Faye's mental and physical health declined significantly after a period when the service failed to visit her several times, and there were no services attending her home.

> **At Christmas time, nobody was going to support her. The organisation who was meant to support her forgot about her.**

Following an accident when she tripped on an escalator, Faye refused treatment for her physical injuries. In another incident she had her nose, chest and ribs broken late at night in the city. Tina related that '[s]he soldiered on for a while but eventually, I had to take her to hospital.'

Tina said Faye's mental health declined considerably after this. She was admitted to a psychiatric inpatient unit and was administered electroconvulsive therapy.

At this stage, Faye moved in with Tina and she was linked with an aged persons mental health service, which provided Faye with community-based case management support. Faye is also currently on the waiting list seeking approval for support from the Commonwealth aged care system. Tina spoke positively about her experiences with the aged persons mental health service but expressed concern that nobody is monitoring Faye's medication closely enough. She needs to ensure that Faye is taking it.

> **Every night I have to check Faye has swallowed her medication.**

Tina also highlighted how her own physical health difficulties have had an impact on her ability to care for her sister. She said that Faye appears to be in better physical health than her, despite Faye being older. Tina applied for an aged care package for

herself but this was rejected. She has, however, been able to receive some funding through a carer consultant at the aged persons mental health service.

> I look after two people with mental health challenges alongside my physical illness. I need some sort of emotional help, and practical help, like cleaning the gutters.

The carer consultant also tried to access a respite retreat for Faye to attend, but this was unsuccessful because it was not culturally appropriate. Faye had specific needs that the retreat could not meet, such as an interpreter, a special diet, and ways to pursue her Chinese-specific interests—for example, access to her usual Chinese language television programs.

Despite all of the demands on Tina, she is positive about her role in supporting her family.

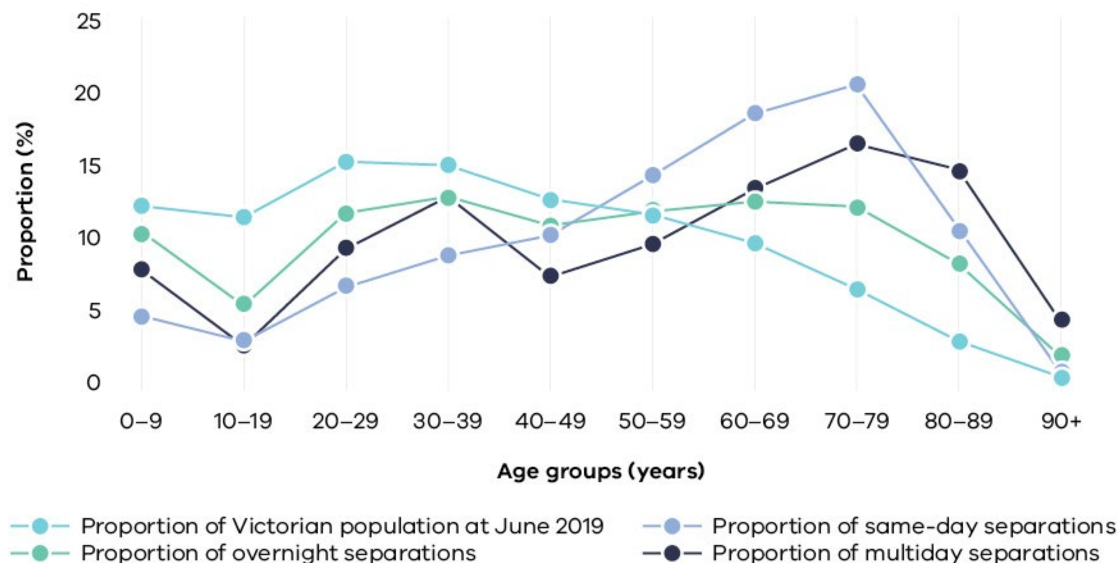
> All of us three people, we support each other.

Source: RCVMHS, *Interview with 'Tina' (pseudonym)*, September 2020.

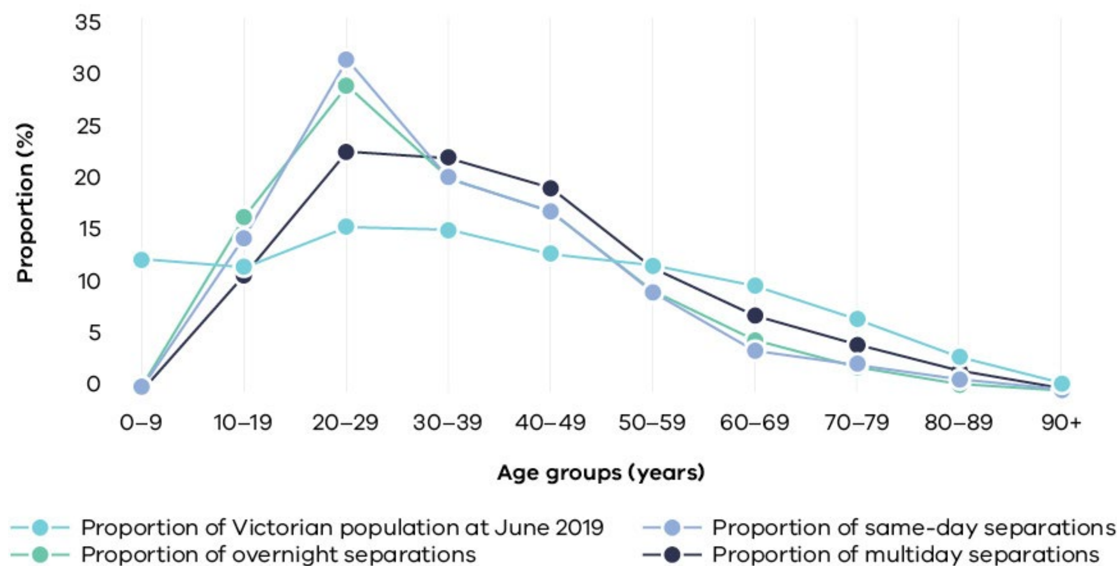
Note: * Names have been changed to protect privacy

Figure 14.9: Proportion of all separations in public hospitals compared with the Victorian population, by age group and length of stay type, Victoria, 2018–19

A. Acute admitted non–mental health separations



B. Acute admitted mental health separations



Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store, Victorian Admitted Episodes Dataset 2018–19; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat.no. 3101.0, Canberra.

Notes: Acute admitted mental health separations includes the following care types: 5K Acute, Child and Adolescent Mental Health (CAMHS); 5G-Acute, Aged Persons Mental Health (APMH); 5S-Acute, Specialist Mental Health; and 5A-Acute, Adult Mental Health. Acute admitted non–mental health separations includes the following care type: 4-Other (Acute) Care including Qualified newborn. 4-Other (Acute) Care including Qualified newborn includes: same-day and acute (except mental health); same-day electroconvulsive therapy episodes; acute episodes in which an electroconvulsive therapy has been performed but the care is not principally mental health; Newborn who has been a qualified newborn for some or all of the duration of this episode. Excludes patients admitted to designated units and programs covered by other care types; newborn who has been an unqualified newborn for the entire duration of this stay (U). A separation is the process by which an episode of care for an admitted patient ceases.

14.3.1 Access and navigation challenges

The Commission was told that older Victorians and their families, carers and supporters can experience challenges in accessing and navigating the various supports that are available under the Commonwealth's aged care system and Victoria's mental health system.[94]

As Mental Health Victoria and the Council on the Ageing Victoria stated in their joint submission to the Commission:

> **The mental health system is complex and finding an appropriate service can be difficult for consumers, their families and carers, and even for health professionals. At present people must negotiate their way around various Commonwealth, Primary Health Network stepped care and state-based services with little clarity as to who provides what. Dealing with a mental health condition, or supporting someone with one, can be stressful enough without the added stress of having to navigate a bewildering system to find appropriate support.**[95]

It is widely recognised that the aged care sector's 'incomplete and overlapping' intersections with state and territory mental health systems makes it difficult for consumers to navigate.[96] The Royal Commission into Aged Care Quality and Safety also recognised that the aged care system, as part of a broader system of health and human services, can be challenging to navigate and that older Australians often 'experience complex journeys through disconnected systems to get their needs met'.[97]

This issue is exacerbated for people from diverse groups, such as culturally diverse communities and LGBTIQ+ communities, who often struggle to find accessible and responsive services.[98]

The Royal Commission into Aged Care Quality and Safety ran concurrently with this Commission and is investigating the Commonwealth's aged care system. The Royal Commission into Aged Care Quality and Safety identified the need to clarify the interface between the aged care system and state and territory health systems in its interim report and background papers, and appears likely to outline opportunities for reform in its final report.

The Victorian Government should wait on the outcomes of the Royal Commission into Aged Care Quality and Safety's final report, and then seek to work with the Commonwealth to ensure older Victorians with mental health illness and psychological distress have a seamless and integrated experience of the mental health and aged care systems.

14.3.2 Confusion regarding residential aged care facilities

There is a particular lack of clarity regarding residential aged care services' responsibility to provide a full range of mental health treatment, care and support to residents. As identified by the Senate Community Affairs References Committee's 2019 report, it is not clear whether the Commonwealth's residential aged care facilities are responsible for providing supported accommodation or health care.[99] The Royal Commission into Aged Care Quality and Safety also identified a need for the Commonwealth to clarify the role and responsibilities of residential aged care providers to maintain the mental health of residents.[100]

People living in residential aged care facilities appear to experience higher rates of mental illness or psychological distress than older Victorians living in the community.[101] As the Australian Institute of Health and Welfare identified, as of June 2012, 52 per cent of all permanent aged care residents had 'mild, moderate or major symptoms of depression' at their last assessment.[102] This compares with the 10–40 per cent of older Victorians in the community estimated to be experiencing symptoms of depression.[103]

Further, permanent aged care residents often have higher and more complex mental and physical healthcare support needs. As of June 2019, 87 per cent of people in permanent residential aged care had at least one diagnosed mental health or behavioural condition, 53 per cent had a diagnosis of dementia and 64 per cent 'had a high care need rating in the cognition and behaviour assessment area'.[104]

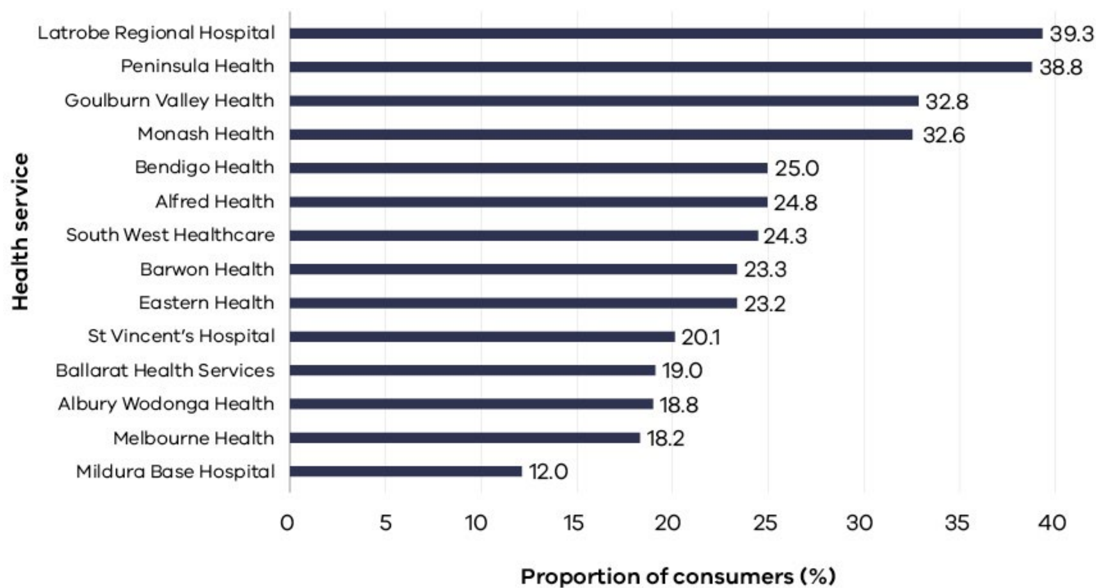
As witnessed in recent years, residential aged care facilities are not sufficiently meeting the mental health needs of residents.[105] While staff working in these facilities play a critical role in supporting the mental health and wellbeing of older Victorians, they often lack the skills, training and resources required to identify mental health and wellbeing concerns, make appropriate referrals and provide support.[106] Furthermore, the approach taken to supporting the mental health needs of residents of aged care facilities varies depending on the individual facility.[107]

As the Commonwealth explained in its 2018 guidance document, *Psychological Treatment Services for People with Mental Illness in Residential Aged Care Facilities*, Primary Health Networks are responsible for commissioning mental health treatment, care and support for residents with 'mild to moderate symptoms of common mental illness'.[108] The guidance document also outlines that there are some older Victorians with more 'severe and persistent or complex needs'.[109] The same group also requires 'specialist mental health services' delivered by state and territory governments.[110]

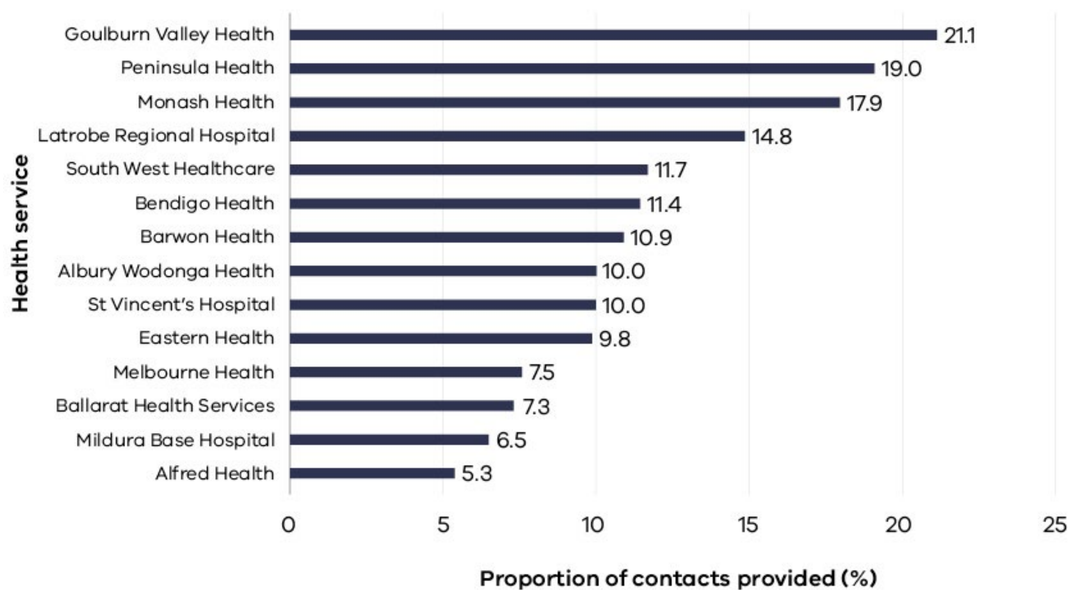
Victoria's existing aged persons mental health services take a varied approach to working in and with residential aged care facilities. The Commission's analysis of aged persons mental health services' community contact data (presented in Figure 14.10) indicates that each health service takes a very different approach to working within mainstream residential aged care facilities. The first part of Figure 14.10 shows that in some areas, such as those serviced by Latrobe Regional Hospital or Peninsula Health, almost 40 per cent of consumers were reported as living in a residential aged care facility, while in other areas this number was as low as 12 per cent. The second part of Figure 14.10 indicates that for residents of aged care facilities who did receive support, the level of service received (or the proportion of contacts provided) also differed. For example, Goulburn Valley Health provided more than 20 per cent of its contacts to people living in mainstream residential aged care facilities, while Alfred Health provided just 5 per cent of its contacts to those living in residential aged care. Note, this data does not include Victoria's specialist public sector residential aged care facilities.

Figure 14.10: Proportion of aged persons mental health services consumers/contacts that were provided face to face within residential aged care settings where the client was present, by health service, Victoria, 2019–20

A. Proportion of consumers



B. Proportion of contacts



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

Notes: Mental health community data reporting may vary across health services. The data shown only includes consumers and contacts for aged care residential services and excludes aged persons mental health residential services.

Case study:

Behavioural Assessment and Specialist Intervention Consultation Service

In response to enormous population growth and the closure of some specialist public sector residential aged care facilities in the region, NorthWestern Mental Health's Aged Person Mental Health Service established the Behavioural Assessment and Specialist Intervention Consultation Service (BASICS) in 2016.

Jan Hocking, BASICS' Program Manager, said that given the ageing population and increasing prevalence of mental illness in the area, BASICS was set up to deal with the longer term demand for aged person mental health service tertiary services and increase equality of service provision for those living in residential settings. Ms Hocking said the program recognises the specific needs of residents in aged care.

> Aged care residents are remarkably marginalised in terms of access to good health supports. Because of the higher mental health needs this cohort experiences, we realised this needed to be managed by a particular skill set rather than that which exists in the aged care teams.

The BASICS model comprises a dedicated team, including a social worker, manager, clinical psychiatrist, neuropsychiatrist and registered nurses, who provide specialist mental health treatment, care and support to people living with severe mental illness in more than 150 residential aged care facilities across the north and west of metropolitan Melbourne.

Ms Hocking said that this model focuses on partnering with residential aged care services and building the skills of aged care staff so they feel more confident in providing ongoing support to people with severe or complex mental health issues.

> The focus of the teams is on capability building and establishing and maintaining relationships, which requires a detailed understanding of the residential aged care sector. We use a consultation-liaison model, where BASICS staff go into the residential aged care facility and work really closely with staff and carers, modelling behaviours and interventions until they are confident to provide support on an ongoing basis.

The service primarily supports those living in residential aged care facilities and also provides some support to those being discharged or transitioned from an aged persons mental health service acute inpatient unit into a residential aged care facility. It sits separately from the broader community assessment and treatment team, which supports older Victorians in community settings.

Ms Hocking noted that given BASICS operates in aged care settings, it works closely with Commonwealth-funded services, such as Dementia Behaviour Management Advisory Services and Severe Behaviour Response Teams. Ms Hocking said they try to 'support and partner with these programs' so that BASICS staff can take broader responsibility for residents' mental health while the other programs focus on specific support for complex issues such as dementia.

Source: RCVMHS meeting with NorthWestern Mental Health's Aged Person Mental Health Service, 3 September 2020; NorthWestern Mental Health, Behavioural Assessment and Specialist Intervention Service, <www.nwmh.org.au/professionals/services/older-people/behavioural-assessment-and-specialist-intervention-consultation>, [accessed 20 November 2020].

A number of health services pointed to NorthWestern Mental Health's Behavioural Assessment and Specialist Intervention Consultation Service (BASICS) as a better practice example of how aged persons mental health services can work within residential aged care services.[111] This model involves a dedicated team that partners with residential aged care providers to deliver mental health treatment, care and support to residents with the need for ongoing intensive treatment, care and support. The BASICS team aims to train and improve the skills of aged care staff, enabling them to provide longer term care to these residents. This model both supports aged care staff to better meet the mental health needs of residents and seeks to manage increasing demand for Victoria's acute inpatient units.

The BASICS approach has similarities with other service models recommended by the Commission throughout this report. For example, the Commission has recommended that Forensicare provides a Specialist Behaviour Response Team that will support Adult and Older Adult Area Mental Health and Wellbeing Services to strengthen their capacity to respond to consumers who are extremely agitated, distressed and placing the safety of themselves, other consumers and staff at risk.

Similarly, BASICS works with residential aged care services to strengthen their capacity to support residents living with mental illness who have ongoing intensive treatment, care and support needs. More detail on the Commission's recommended Specialist Behaviour Response Team can be found in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*.

Following the outcomes of the Royal Commission into Aged Care Quality and Safety's final report, the Victorian Government will need to work with the Commonwealth Government to agree the preferred approach to providing specialist inreach services for residents living with mental illness who have ongoing intensive treatment, care and support needs. The Commission considers that the Victorian Government should work with the Commonwealth to agree an approach similar to that provided by the BASICS team, which will need to be jointly funded to ensure it is adequately resourced.

This model should be in the interests of the Commonwealth because it will improve the capability of aged care staff to care for residents with mental illness or psychological distress.

The Commission considers it critical that people living in residential aged care facilities are provided with the same access to mental health services as the rest of the Victorian population.[112]

14.3.3 A lack of role clarity in supporting people with complex signs and symptoms of dementia

There is currently a lack of clarity regarding the role of the Victorian Government and the Commonwealth Government in supporting people with complex signs and symptoms of dementia.

Dementia may be understood to be a 'progressive neurodegenerative disease'[113] (that is, a continued deterioration in functioning).[114] While it is referred to as one disease, there are numerous forms of dementia, with Alzheimer's disease being the most common.[115]

There is a complex relationship between dementia and mental illness. As Dementia Australia stated:

> mental illness is a risk factor for some dementias; depression and anxiety may be experienced as a consequence of dementia; and diagnosing where one condition—and treatment—ends and the other begins is a difficult exercise that has significant implications for the quality of life for Victorians living with dementia.[116]

People with dementia in its later stages can have a wide range of complex needs and require a range of treatment, care and support, such as pharmacological, psychological and psychosocial treatment.[117] For these reasons, psychiatrists, along with neurologists and geriatricians, have a critical role to play in supporting people with dementia.[118]

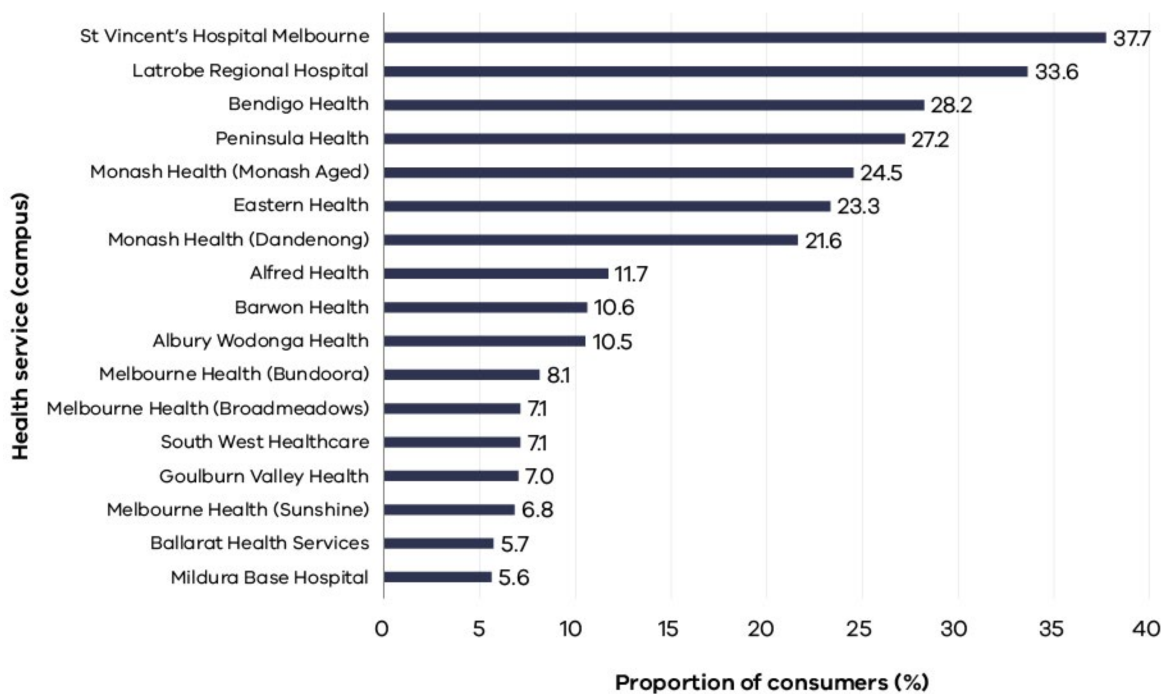
In its 2006 clinical framework, *An Introduction to Victoria's Public Clinical Mental Health Services*, the Victorian Government outlined that aged persons mental health services are responsible for providing support to people with 'psychiatric or severe behavioural difficulties associated with organic disorders such as dementia'.[119] In the past decade, however, the Commonwealth Government has introduced a number of services to support people with moderate to severe dementia—for example, the Specialist Dementia Care Program, the Dementia Behaviour Management Advisory Service and the Severe Behaviours Response Team.

The Commission found that aged person's mental health services vary 'in their responses to requests for help from residential providers regarding residents whose dementia is complicated by behavioural and psychological symptoms'.[120] Aged persons mental health services data illustrates the level of variation in admissions to acute inpatient services across Victoria. As shown in Figure 14.11, one health service in 2018–19 recorded 37.7 per cent of admissions as having a principal diagnosis of dementia, while another recorded only 5.6 per cent.

The absence of an agreed, consistent approach across the state risks causing confusion for consumers, their families, carers and supporters, as well as service providers. One person described the impact of this inconsistency on her role as a carer for her late mother:

> Our experience was one of being shunted from facility to facility. From a general ward within a hospital, to a rehabilitation facility (connected to the hospital) back to the hospital through the Emergency Department as the rehabilitation facility found it 'too hard' to get the consultation liaison inpatient psychiatry service to visit, transferred to an aged person mental health unit as an out of area admission and finally transferred back to the mental health aged acute inpatient unit of the hospital where we first started three months earlier … Too many strangers, too many environments and changes and too much noise all contributed and exasperated my mother's agitation and triggered BPSD [behavioural and psychological symptoms of dementia] symptoms.[121]

Figure 14.11: Proportion of admitted aged persons mental health service consumers with a principal diagnosis of dementia, by campus, Victoria, 2018–19



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store, 2018–19.

Note: Includes separated episodes across all admitted aged settings.

While the Commonwealth Government—through both the primary and aged care systems—is principally responsible for providing support to people with dementia, the Victorian mental health system has a role to play in providing specialist treatment, care and support to people with highly complex presentations of dementia. The Commission also recognises a need for the Commonwealth's aged care system and the Victorian mental health and wellbeing system to work more closely to reduce access and navigation challenges for consumers, their families, carers and supporters.

The Royal Commission into Aged Care Quality and Safety is likely to comment on the Commonwealth's role in delivering dementia services in its final report.

Following the release of the Royal Commission into Aged Care Quality and Safety's final report, the Victorian Government should work with the Commonwealth to develop an agreed framework for service delivery that clearly articulates the role of Victoria's mental health and wellbeing system in providing treatment, care and support to people experiencing complex signs and symptoms of dementia, and their families, carers and supporters.

This should include:

- ease of access and navigation for consumers, their families, carers and supporters, and relevant service providers (such as residential aged care facilities)
- identifying and assessing the needs of this cohort, and clearly determining the appropriate referral pathways
- an agreed model of care for these consumers, particularly in Victoria's acute inpatient units.

In November, on the release of the Productivity Commission's *Mental Health Inquiry Report*, the Prime Minister acknowledged the need to clarify roles and responsibilities between the Commonwealth and state governments in relation to the 'grey area' between primary care and specialist mental health services.[122] This process, and the development of the new *National Mental Health and Suicide Prevention Agreement* by November 2021, may present a good opportunity for the governments to consider roles and responsibilities in relation to caring for people with complex signs and symptoms of dementia as a priority for reform. Chapter 29: *Encouraging partnerships* outlines the opportunities for Victoria to work with the Commonwealth in implementing the future system.

14.4 The future mental health and wellbeing service stream for older Victorians

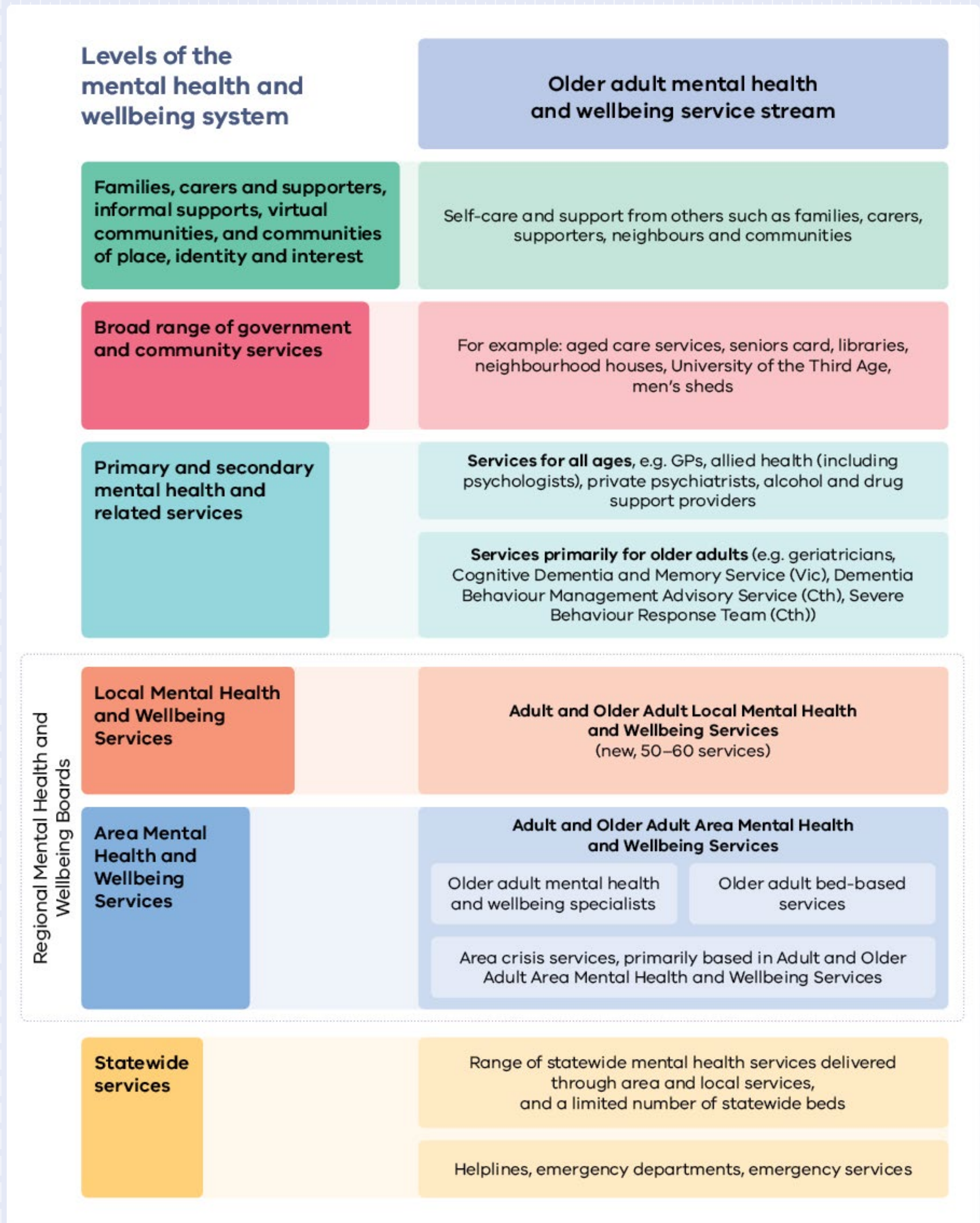
In response to the issues described earlier, the Commission has developed reforms for a new, responsive and integrated mental health and wellbeing service stream, within the adult and older adult mental health and wellbeing system, to support improved mental health and wellbeing outcomes of older Victorians. This will work to provide older Victorians with greater choice and encourage them to continue to maintain their independence and live contributing lives.

The future mental health and wellbeing system will be grounded in primary and secondary mental health and related services. This means that most older Victorians will have their mental health treatment, care and support needs met by their GP and other primary and secondary care and related services in their local community. As discussed in more detail throughout the remainder of this chapter, older adult mental health and wellbeing specialist multidisciplinary teams will provide specialist backup and inreach support to primary and secondary mental health and related services.

Adult and Older Adult Local Mental Health and Wellbeing Services will also provide integrated treatment, care and support for adults and older adults whose needs cannot be met in primary or secondary care alone. This will mean that older Victorians have equal access to the treatment, care and support described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*. A summary overview is also provided in Figure 14.12 and in the next section.

The Commission has also recommended that the Victorian Government implements eight social prescribing trials across Victoria's Adult and Older Adult Local Mental Health and Wellbeing Services. The Commission heard of the value that social prescribing may have for reducing social isolation and loneliness, and promoting the mental health and wellbeing of older Victorians by helping to connect people to existing initiatives in the community that support increased social connection (such as the University of the Third Age and men's sheds).[123] Older Victorians will be a priority group for the social prescribing trials, which are described further in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

Figure 14.12: An overview of the future mental health and wellbeing system—older adults



Developmentally appropriate transitions will be applied between age-based systems and service streams

Some people will have complex mental health needs generally related to ageing. In the future Victorian mental health and wellbeing system, the dedicated older adult mental health and wellbeing specialist multidisciplinary teams within the Adult and Older Adult Area Mental Health and Wellbeing Services will provide mental health treatment, care and support to those with complex and compounding mental health issues generally related to ageing (irrespective of the person's chronological age).

Access to older adult mental health and wellbeing specialist multidisciplinary teams will be determined on a case-by-case basis, taking into consideration the developmental needs of each individual, as well as their preferences.

The same process will apply to those who need a period of treatment, care and support in a bed-based service. Older Victorians who may be better suited to receive mental health treatment, care and support within an adult bed-based service (for example, due to their prior experience with these services or their mental health and wellbeing needs) will not be required to transition due to their age. Similarly, people who may be better suited to an acute inpatient unit that is dedicated to supporting people with complex and compounding mental health issues generally related to ageing will be able to access these services irrespective of their age.

The Commission's recommendations designed to improve the quality and safety of Victoria's mental health and wellbeing services will help ensure older Victorians receive high-quality and safe treatment, care and support in acute inpatient units. These recommendations are outlined in Chapter 30: *Overseeing the safety and quality of services* and include:

- the Mental Health and Wellbeing Commission monitoring, inquiring into and reporting on the system-wide quality and safety of mental health and wellbeing service delivery
- the Mental Health Improvement Unit within Safer Care Victoria working with mental health and wellbeing services to design quality and safety improvement programs.

There will also be reforms to address the concerns relating to the acute inpatient units' physical environments and infrastructure. As discussed in Chapter 28: *Commissioning for responsive services*, the Victorian Government will establish a mental health service and infrastructure planning process, including the publication of statewide and regional plans that will map current and future service and demand, and will identify areas of greatest need for further investment. This process will consider the configuration, location and condition of all facilities (including therapeutic design principles), including services for older Victorians.

To guide delivery of the future older adult mental health and wellbeing service stream, the Victorian Government will work with older Victorians, their families, carers and supporters, as well as service providers and sector experts, to co-design and co-deliver a 10-year service plan. This plan should clarify the roles and responsibilities of Victoria's mental health and wellbeing services in relation to the Commonwealth's aged care system to reduce confusion for consumers, their families, carers and supporters, and service providers. Service planning is covered in detail in Chapter 28: *Commissioning for responsive services*.

14.4.1 Building on the Royal Commission into Aged Care Quality and Safety's recommendations

On 30 September 2020, the Royal Commission into Aged Care Quality and Safety provided a special report to the Commonwealth Government on aged care and COVID-19. The report outlined six recommendations for the Commonwealth to support older Victorians receiving aged care services.

One of these was to create Medicare Benefits Schedule items to increase mental health services to aged care residents during the COVID-19 pandemic:

> The Australian Government should urgently create Medicare Benefits Schedule items to increase the provision of allied health services, including mental health services, to people in aged care during the pandemic. Any barriers, whether real or perceived, to allied health professionals being able to enter residential aged care facilities should be removed unless justified on genuine public health grounds.[124]

The Commission supports this recommendation and considers that to ensure these supports are used, there may need to be incentives (such as cost reimbursements) provided to mental health professionals to cover the additional costs associated with travelling to residential aged care facilities.

14.4.2 Supporting primary and secondary mental health and related services

The Commission identified a need to better equip GPs and other primary and secondary mental health and related professionals to support the mental health and wellbeing of older Victorians.

As discussed earlier in this chapter, older Victorians appear less likely to engage with mental health services and to actively seek mental health support. When they do seek support, it is more likely to be through their GP. A survey conducted for the Commission also found that older Victorians are more likely than younger adults to go to their GP for information about mental health than friends or family, or online platforms.[125] This indicates that GPs play an even more critical role in supporting the mental health needs of older Victorians than other age groups, and it is therefore critical that they are able to proactively identify older people's needs for mental health and wellbeing treatment, care and support.

However, the Commission also found that GPs and other health professionals can fail to identify mental illness in older Victorians because they sometimes identify relevant behaviours as being normal parts of the ageing process.[126]

Under current arrangements, the Commonwealth is largely responsible for improving the capability of GPs and other health professionals. Primary Health Networks are primarily responsible for improving the skills and knowledge of GPs and other health professionals to work with people experiencing mental illness.[127] The Royal Australian College of General Practitioners also plays a role in building the capability of GPs, registrars and medical students.[128]

One of the core functions to be delivered by Victoria's future older adult mental health and wellbeing specialist multidisciplinary teams is providing specialist backup and inreach support for primary and secondary mental health and related providers. This will include secondary consultation with service providers, primary consultation with their consumers, and a formal model of comprehensive shared care. Through these supports, older adult mental health and wellbeing specialist multidisciplinary teams will provide specialist advice and support to these workforces to better equip them to support the mental health needs of people with complex and compounding mental health issues generally related to ageing. This will also be important for supporting those who are experiencing concurrent health and other issues such as alcohol and other drug use.

As outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, supports for primary and secondary mental health and related services will be one of the core functions of adult services, which will be delivered in each region. Older adult mental health and wellbeing specialist multidisciplinary teams will contribute to the delivery of this function, working with providers where there is a need for specialist expertise in mental health issues generally related to ageing.

14.4.3 Local community-based mental health and wellbeing services for older Victorians

There is a need to increase the service options that are available to older Victorians with mental illness or psychological distress, and to shift from a predominantly medical model to one that provides older Victorians with a broader range of mental health and wellbeing supports.

There is a tendency for some GPs and mental health professionals to over-rely on medication, and there is too often a lack of alternative options—such as psychotherapy—available to support older Victorians with mental health issues.[129] As Dr Maria Tsanglis, Director of Aged Psychiatry at Alfred Health, stated:

> there's a real lack of therapy in [community mental health]. You know, depression for example, the evidence is clear that psychotherapy and medication are the best treatment approach, but most people will receive some medication and might have some case management support, but no real therapy … it's very much a medical model. And I'd like to see that change …[130]

The National Ageing Research Institute also highlighted this issue to the Commission and noted there is a body of evidence that suggests that older Victorians respond positively to cognitive behaviour therapy and other psychotherapies.[131]

As outlined in Chapter 5: *A responsive and integrated system*, the Victorian Government will establish Adult and Older Adult Local Mental Health and Wellbeing Services that will provide integrated, multidisciplinary mental health treatment, care and support. Older Victorians will have equal access to the mental health and wellbeing supports that are provided to the rest of the adult population.

Adult and Older Adult Local Mental Health and Wellbeing Services will deliver a wide range of mental health and wellbeing services—ranging from peer support groups and therapies through to support in accessing and navigating other service systems, such as those relating to housing and aged care.

This will respond to the concerns expressed by several older Victorians about the lack of psychosocial (or wellbeing) supports that are available when they turn 65 years of age:

> We need to re-vision the model across the spectrum of illness[,] the episodic nature of mental illness and the division between age cohorts. Services are less accessible for people aged over 65 and there is a lessening of the range of supports available, including a decline in psycho-social rehab services.[132]
>
> We need more social program support to connect to the community and a more social model.[133]

While all of the programs and supports provided by Adult and Older Adult Local Mental Health and Wellbeing Services will be available to older adults, there will also be some programs that are tailored specifically for older Victorians. For example, there might be dedicated peer support groups and group programs for older Victorians and older families, carers and supporters.

The Victorian Government will ensure older Victorians can easily identify and access Adult and Older Adult Local Mental Health and Wellbeing Services through:

- ensuring facilities are openly identified as being for adults and older adults; this means the government will need to consider how to name, market and brand these services
- providing face-to-face alternatives for older Victorians to access advice and support in addition to websites and phonelines
- making available local parking (including disabled parking places) and community transport options
- ensuring that primary and secondary mental health and related services, and aged care services, are aware of the inclusive age range of these services, and the supports that are available to older Victorians through them. This will help create appropriate referral pathways and clearer access and navigation for consumers, their families, carers and supporters.

14.4.4 Adult and Older Adult Area Mental Health and Wellbeing Services

Victoria's aged persons mental health services currently play a critical role in the mental health system. Older Victorians identified the community assessment and treatment teams, inpatient units and specialist mental health public sector residential aged care services as strengths in the current system that should be built upon and invested in.[134]

There is a need for dedicated, specialist mental health and wellbeing services to provide treatment, care and support to people with 'complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually relating to ageing'.[135] This will include those who have lived with ongoing and episodic mental illness during their adult years, as well as those who develop complex mental health challenges in their later years. These services will comprise multidisciplinary teams with a wide range of expertise and experience, including peer workers, nurses, consultant psychiatrists and other doctors, social workers, psychologists, support workers and occupational therapists.[136]

In the future system, the existing aged persons mental health services will be reformed to establish the older adult mental health and wellbeing service stream, made up of bed-based services for older adults and older adult mental health and wellbeing specialist multidisciplinary teams based in Adult and Older Adult Area Mental Health and Wellbeing Services. Older adult mental health and wellbeing specialist multidisciplinary teams will undertake two functions:

- direct provision of mental health treatment, care and support for older Victorians with complex and compounding mental health needs generally related to ageing (this will be based in area services, but be delivered through both area and local services where possible)
- specialist support for primary and secondary mental health and related services, including aged care and public sector residential aged care services, through primary consultation with consumers, secondary consultation with providers of those services and a formal model of comprehensive shared care.

Older adult mental health and wellbeing specialist multidisciplinary teams will provide specialist support to primary and secondary mental health and related services, including aged care, Local Mental Health and Wellbeing Services and public sector residential aged care services. Increased specialist inreach support will enable higher quality treatment, care and support for older Victorians in these settings and may reduce demand for acute inpatient services in time.[137]

Older adult mental health and wellbeing specialist multidisciplinary teams will also take a more flexible approach to service delivery than they currently do. During the COVID-19 pandemic, health services found that some consumers preferred to connect via telehealth, and this approach has proven particularly effective in engaging some consumers, families, carers and supporters.[138]

As part of this more flexible approach to service delivery, older adult mental health and wellbeing specialist multidisciplinary teams can take advantage of telehealth while continuing to provide services face to face as appropriate in the following settings:

- community-based clinics
- residential aged care services
- private homes and other places in the community.

Older adult mental health and wellbeing specialist multidisciplinary teams will determine the most appropriate approach to service delivery on a case-by-case basis. A mixed approach may be the most appropriate—for example, using telehealth for one session and then seeing the consumer in a community clinic for the next session. This model will be an improvement on the current approach, where aged persons mental health services rely more heavily on home visits than area mental health services for other age groups.[139] In some regions, this may be because of a lack of physical clinic-based infrastructure to provide services.[140]

Reducing the current balance of home visits for this cohort and making clinic-based services more consistently available across regions will ensure older Victorians have the choice between being seen within their private home and receiving support in other settings. It will also reduce the amount of time staff are spending on travel.[141]

Clinic spaces also provide more opportunities for older Victorians to socially connect, as individuals will be exposed to more incidental social interactions (for example, engaging with reception staff) and can be more readily connected with group-based activities, such as peer groups, recovery colleges and social activities.

The Commission recognises, however, that providing support to people within their homes continues to be an important and effective way to deliver services for some consumers and acknowledges that it is promoting a shift towards this model for other age groups and in other contexts.

14.4.5 A stronger focus on developmental needs

The current age boundary of 65 years will be removed and access to the older adult mental health and wellbeing service stream (including bed-based services and older adult mental health and wellbeing specialist multidisciplinary teams) will instead be determined on a case-by-case basis considering the developmental needs of each individual. Services in the older adult mental health and wellbeing service stream will be provided to people with complex and compounding mental health issues generally related to ageing, irrespective of whether the person is 45 years of age or 85 years of age.

Under this reform, older Victorians will be able to access and receive the full range of services that are provided under the adult system, including Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, through to acute inpatient units and prevention and recovery care services.

The age boundary of 65 years may continue to be used for service planning purposes. This will enable government and services to plan around a target population, informing activities such as demand forecasting and investment. Sixty-five years of age is an appropriate boundary for these purposes, given its alignment with other age boundaries used across Australia—for example, the National Disability Insurance Scheme, the aged care system and other state and territory mental health services.

14.4.6 The state's role in delivering specialist mental health residential aged care

Under the current aged persons mental health service system, the Victorian Government delivers specialist mental health residential aged care services. These are primarily operated by public health services in rural and regional Victoria.

Such services differ from mainstream residential aged care facilities in that they provide longer term specialist mental health treatment, care and support for people with more complex and persistent care needs—that is, those who cannot be effectively supported in mainstream facilities.

In 2018–19, there were 498 funded residential mental health beds for older Victorians.[142] This is the highest number of specialist public sector mental health residential aged care beds when compared with other Australian states and territories.[143]

Similar to the aged persons mental health services' acute inpatient units, the majority of these facilities are increasingly in need of a physical infrastructure upgrade or rebuild.[144]

There is a continuing need for the Victorian Government to maintain a role in supporting the consumers using these services, as the Commonwealth's existing funding for mainstream residential aged care facilities is not sufficient to meet the care needs of people with severe or complex mental illness.[145]

However, there are different models or approaches to service delivery that the Victorian Government may consider. For example, in New South Wales, the Ministry of Health provides top-up funding to non-government organisations to cover the additional costs associated with providing care to consumers with complex mental health needs. This is in addition to any Commonwealth aged care funding that the provider may be receiving. Local older adult mental health services then partner with the residential aged care facility to provide specialist input and support the mental health treatment, care and support of residents.[146]

This model already exists in some regions within Victoria, and there is anecdotal evidence that it may be an effective alternative. For example, Dr Tsanglis spoke positively of Alfred Health's experiences working with HammondCare, a third-party provider that specialises in dementia care. She described to the Commission the way that this provider—using new, purpose-built facilities—has been able to increase the quality of care that is provided to consumers and reduce the number of admissions to acute inpatient services.[147]

The Royal Commission into Aged Care Quality and Safety is currently reviewing the Commonwealth's funding model for residential aged care services, and large-scale reform in this sector is expected.[148] Once the Commonwealth Government responds to the Royal Commission into Aged Care Quality and Safety's final report, the Victorian Government should undertake a comprehensive review of the state's approach to these services and consider:

- the quality of care provided to consumers in these facilities
- the likelihood of appropriate care being given to this consumer group through other services and systems (the Commonwealth's residential aged care facilities)
- the state of the physical environment and infrastructure
- the configuration and location of the facilities across Victoria
- the merit of alternative models for service delivery (for example, a partnership approach).

This will inform the Victorian Government's decision regarding the most appropriate approach to delivering mental health services within residential aged care facilities in the future. This review should be undertaken, and a decision made, within the next three to five years.

1 Victorian Government, *Royal Commission into Victoria's Mental Health System—Letters Patent*, 2019, para. III(e).

2 Department of Environment, Land, Water and Planning, *Victoria in Future 2019: Population Projections 2016 to 2056, 2019*, p. 8.

3 United Nations, *World Population Ageing Highlights*, 2017, p. 1.

4 Department of Environment, Land, Water and Planning, *Victoria in Future 2019*, 2019.

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Chapter 15

Responding to trauma

Recommendation 23:

Establishing a new Statewide Trauma Service

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, establish a Statewide Trauma Service hosted within the Collaborative Centre for Mental Health and Wellbeing, to deliver the best possible mental health and wellbeing outcomes for people of all ages with lived experience of trauma.
2. fund the Statewide Trauma Service to bring together mental health practitioners, trauma experts, peer workers and consumers with lived experience of trauma to:

    a. conduct multidisciplinary and translational trauma research;

    b. develop and deliver education and training that supports Victoria's mental health and wellbeing workforce to deliver trauma-informed care;

    c. develop and oversee digital peer-led support platforms offering consumers access to peer support networks; and

    d. coordinate and facilitate access to specialist trauma expertise, including secondary consultation for mental health practitioners and peer workers across Victoria's mental health and wellbeing system.

Recommendation 24:

A new approach to addressing trauma

The Royal Commission recommends that the Victorian Government:

1. in collaboration with the Statewide Trauma Service (refer to recommendation 23), enable each of the 22 Adult and Older Adult Area Mental Health and Wellbeing Services and each of the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b) and (c)) to employ up to three specialist trauma practitioners to:

    a. work with peer support workers in Local Mental Health and Wellbeing Services to provide and facilitate access to a broad range of trauma supports for consumers of all ages and backgrounds; and

    b. contribute to the ongoing learning and professional development of the mental health and wellbeing workforce through supervision, consultation and shared clinical care.

15.1 Recognising and responding to the mental health and wellbeing impacts of trauma

During the Commission's inquiry, consumers bravely shared their experiences of trauma, defined by one witness as 'a personal and painful experience of being harmed and having little or no power to prevent it'.[1] Consumers shared horrific recounts of violence, sexual assault, torture, natural disasters, child abuse and other experiences. Although the range of traumatic events described to the Commission was broad, consistent throughout the stories was the significant level of harm that trauma has on individuals, families, carers and supporters and, in some instances, entire communities.

While exposure to trauma is a relatively common occurrence,[2] an agreed position on the mental health impacts of trauma has been slow to develop among mental health professionals:

> Stress, adversity and trauma affects everyone and the earlier it starts in life, the longer it lasts, the more frequently it happens, and the more distrust develops, the more challenging and long-lasting the effects will be. It is because of this complexity and the intersection with so many other dimensions of science and the humanities that it has become possible for a unified field theory of human behaviour to begin to emerge. A paradigm shift is finally occurring after several hundred years of advancing knowledge that can integrate and unite the varied schools of thought about trauma and the human condition.[3]

A growing body of evidence describes the link between mental illness and exposure to trauma.[4] Despite this, some persistent scepticism remains about both the condition and effect of trauma on individuals.[5] In fact, evidence describes how, historically, the impacts of trauma on mental health have been largely 'overlooked and greatly underestimated'[6] in medical practice.

It is increasingly evident that the predominance of the biomedical model, which focuses on 'diagnosis and illness', has restricted the mental health system in its capacity to recognise and respond to the mental health and recovery needs of consumers affected by trauma.[7] It has resulted in a range of structural, capacity, capability and cultural barriers that limit the extent to which trauma is assessed for and responded to in the mental health system.[8] It has also limited the extent to which the mental health workforce has been equipped or supported to respond to the needs of trauma-affected consumers.[9]

The consequences of this have been substantial and have contributed to the exacerbation of poor mental health outcomes for consumers,[10] with broader impacts on families, carers and supporters.[11] Witnesses described how a failure of the mental health system to enquire about or acknowledge trauma left them feeling 'broken and excluded'.[12] As Ms Indigo Daya, Consumer Academic, Centre for Psychiatric Nursing at the University of Melbourne, stated in a personal capacity:

> Not once during my experience of mental health services, which must have comprised of thousands of hours and a great many people, did a single person ever ask me about trauma or my childhood. In the early days it was on my mind, but I was too ashamed to ever bring it up. I thought, if what had happened to me was important, that surely one of these specialist people would ask me about it. But they told me I had a disease, an illness. There seemed to be no space for the idea that my distress was a meaningful response to terrible things that had happened to me.[13]

Witness, Ms Erica Williams, described how she chose not to disclose experiencing the symptoms of borderline personality disorder (BPD) with mental health professionals in order to avoid having her concerns dismissed:

> I knew I had some of the symptoms (of BPD) because of my own research and because of my trauma history, but doctors did not take me seriously when I mentioned BPD or trauma. This meant that I was afraid to let doctors know about my BPD symptoms – given they did not seem sure how to manage it or did not seem to take it seriously as an illness. I minimised my symptoms to avoid feeling neglected and dismissed. I often felt suicidal and unsafe, and I feared that expressing my feelings would lead to further rejection. At that time, I was really scared. I knew I had certain symptoms and I knew they were related to my trauma history. I did not know if there was any accessible treatment for those symptoms.[14]

Other witnesses described how a critical turning point in their lives was the acknowledgement or self-realisation that their distress 'was not an illness, it was a normal response to extremely abnormal experiences'.[15]

Mr Justin Heazlewood, a witness before the Commission, described how important it was for him to have had the impact of trauma on his life acknowledged:

> At 28 my past finally caught up with me. My career stalling and a three-year relationship ending, I had a relapse of depression. After being prescribed the antidepressant Lexapro I took it for two weeks but did not like the numbing of emotions. Instead, I finally went to a psychologist. In my first session I opened up about my childhood. 'You must have been very anxious as a child,' he reflected, which is one of the most important things anyone ever said to me. At the end of the session he concluded, 'One day you're going to realise how painful your childhood really was.' I loved counselling. Regular sessions with my psychologist allowed me to process the haunting vault of confusion and trauma that had been plaguing me since I'd left home.[16]

Failure to provide early support for trauma can in some instances be particularly detrimental, leading to worsening mental health, reduced responsiveness to treatment[17] and the accrual of 'collateral trauma'.[18] Ms Lucy Barker, a witness to the Commission, stated:

> I know that if I had had some skills earlier in life I probably wouldn't be in the system today. For me, a lot of it stems from childhood trauma and just struggling in an academic sense and not being able to fit in. If I just had just learned how to cope with things, I probably would have had better coping mechanisms than self-harming or trying to kill myself when something goes wrong.[19]

The Royal Commission into Institutional Responses to Child Sexual Abuse highlighted the extreme difficulty, and benefits, for individuals, groups, and the community of '[speaking] the unspeakable and naming the unnameable'.[20] Evidence before the Commission makes clear that a mental health system that screens for trauma is 'crucial'[21] and is 'fundamental' to supporting the recovery of those whose mental health has been affected by an experience of trauma.[22] It is the Commission's position that trauma can inflict considerable harm to the mental health of individuals, families and communities, and that it demands a sustained and system-wide response from the mental health system.

In Victoria's future mental health and wellbeing system, consumers will benefit from integrated treatment, care and support in the community. The pillars of the new system, detailed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services,* underpin the reforms set out in this chapter.

In the future mental health and wellbeing system, consumers affected by trauma will be supported by a new Statewide Trauma Service. This service will be established by the end of 2022 and will deliver exemplary trauma practice across the state. As a priority, the Statewide Trauma Service will bring together practitioners working in the area of trauma, trauma experts, peer workers, and consumers with lived experience of trauma, to consolidate and draw from a contemporary and shared understanding of trauma and its impacts on mental health and wellbeing. In doing so, the Statewide Trauma Service will identify gaps and opportunities for translational research.

A range of education and training programs will be developed and delivered to equip and support the mental health and wellbeing system to consistently and routinely screen for—and respond to—trauma.

The Statewide Trauma Service will train and support a multidisciplinary workforce of specialist trauma practitioners. Each Area Mental Health and Wellbeing Service will employ up to three trauma practitioners, with:

- up to 66 trauma practitioners embedded in the 22 Adult and Older Adult Area Mental Health and Wellbeing Services
- up to 39 trauma practitioners embedded in the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services.

Working alongside peer support workers, trauma practitioners will support consumers to develop a therapeutic recovery plan which facilitates clinical and non-clinical options for treatment, care and support. Trauma practitioners will deliver treatment, care and support in ways that establish a sense of safety, connection and trust for consumers, and which provide flexible and long-term models of care.

These reforms will ensure consumers and the general public are aware of, and have access to, a range of digital information, supports and online peer networks that respond to the diversity of trauma experiences, cultures, languages and identities in Victoria. A digital 'hub' will provide consumers and the general public with access to information, resources and opportunities for social connection. This will aid safe and supported exploration of traumatic experiences with professionals and peers, provide access to information about the mental health and wellbeing impacts of trauma, and options to support choice in the recovery journey.

Critically, these reforms will support people affected by trauma of all types, at all stages of life, and regardless of whether a mental illness has been diagnosed following exposure to a potentially traumatic event. Consumers will be listened to, acknowledged, supported, and will have greater choice and access to trauma support services. Collectively, these supports will bring about important change in the lives of consumers, families, carers and supporters.

The Victorian Government must establish a future mental health and wellbeing system that is informed about trauma. The system must recognise the diversity of trauma experiences prevalent in the community and have the capacity and capability to respond to the needs of consumers who have experienced trauma. A minimum requirement of mental health services is to do no harm. Ensuring that the mental health and wellbeing system does not contribute to the burden of trauma in the Victorian community must be a priority. If harm does occur, the mental health and wellbeing system must make every attempt to ameliorate the impact of that harm and take proportionate measures to prevent it from reoccurring.

15.2 The prevalence of trauma in Victoria

Each year, many Victorians experience or are exposed to traumatic events or circumstances. Over the past five years, 3,413 people ended their lives by suicide in Victoria,[23] with estimates suggesting that for each suicide, 135 people across the broader community are exposed to, or affected by that death.[24] In the same period of time, 1,280 people were killed or seriously injured on Victorian roads.[25]

During the Commission's inquiry, drought, bushfires, a global pandemic and recession have affected the lives of Victorians across the state. In 2020, Victoria was in a declared state of emergency or disaster in January due to bushfires,[26] and again from mid-March until 29 January 2021 due to the COVID-19 pandemic.[27] Prior to 2020, a state of disaster had never been declared in Victoria.[28] The unprecedented social, economic and personal impacts of COVID-19 are likely to increase demands on Victoria's mental health system, both in the short and long term.[29]

The devastating 2019–20 summer bushfires across East Gippsland took the lives of five Victorians and burned more than 1.5 million hectares of land, destroying 313 primary residences, as well as livestock and wildlife.[30] Studies indicated that the cumulative fire front across Australia's east coast contributed to an 'unprecedented smoke related health burden'.[31] In Victoria, smoke was associated with approximately 120 deaths, 331 hospitalisations for cardiovascular problems, 585 hospitalisations for respiratory problems and 401 emergency department presentations for asthma.[32]

Emerging evidence illustrating the profound impact of the fires on affected communities, including the development of post-traumatic stress disorder (PTSD) is consistent with other major disasters. Dr Sara Renwick-Lau, General Practitioner at the Mallacoota Medical Centre, giving evidence in a personal capacity, stated:

> From my research and speaking to other people, the experience of trauma in Mallacoota has not been different to other big traumatic events. There is evidence that if you traumatise 1,000 people in a big traumatic event, the rates of significant PTSD are going to be between 15 to 25%. Approximately 120 people will need interventions to prevent them from developing longer standing PTSD. We know that 50 to 60% of people will suffer from nightmares and hypervigilance and cognitive problems, all common symptoms of trauma in the first four to six weeks. That was evident in Mallacoota. Anger, irritability, an increase in domestic violence and an increase with alcohol abuse are also all recognised to have a greater incidence following traumatic events in the community. Again, this has not been any different in Mallacoota.[33]

Following the Black Saturday bushfires in Victoria in 2009, rates of people experiencing post-traumatic mental illness and requiring professional support in highly impacted, moderately impacted and lightly impacted communities were 26 per cent, 17 per cent and 12 per cent respectively. Five years after those bushfires, rates of people presenting with post-traumatic mental illness requiring support from the mental health system remained at 22 per cent, 10 per cent and 6 per cent respectively for those communities.[34] As well as community members of affected areas, first responders—such as emergency service volunteers, firefighters, ambulance officers and police—are frequently affected by traumatic events.[35]

Personal story:

Anne Dixon

Anne is a survivor of Black Saturday. She described the trauma that continues years after the tragic event.

> I think the biggest problem with those fires was the sheer number of deaths. I think we would have coped a lot easier, if we weren't surrounded by so much death. And in small communities that's really obvious. It's like looking at someone with a mouth full of missing teeth. It doesn't matter how much they smile, all those teeth are still missing.
>
> You look across the road and you're looking down through the bush. And that is where the houses were where four people died.

Anne explained it was years later that people sat back and considered the devastation. She noted there were a lot of services provided for counselling immediately after the fires, but people were busy after the fires: finding somewhere to live, organising insurance, deciding whether to rebuild.

> It's the two and a half to three years when everyone finally stops and sits down. That's when the mind takes over and when you start to really struggle. You survived the fire, you survived the rebuilding, now you are sitting there and it's not the same as it was before. It's nowhere near it.

Anne said it was important to have services such as Centrelink, the Department of Health and Human Services and the local council located close by and working in a combined effort for at least a year after the fires.

> The services need to be face-to-face in a one-stop-shop. There is a limit to what you can do online if your computer has been destroyed.

She explained that staff from Centrelink moved into the area temporarily and their connection to the community was important.

> They had offices in portable classrooms behind the library at Kinglake and that was great, especially as we had so many damaged people. The thought of having to go to Centrelink every time to explain, 'I've lost my husband', or being asked 'why aren't you looking for work?', well, I'm homeless. You did not have to explain and justify yourself over and over.

While support services were provided to the community, Anne said not everyone recognised they needed help, and the services were not always provided at suitable times.

> There are lots of support groups formed afterwards. There is a lot of peer support and counselling offered through formal groups such as CFA, but a lot of people, especially people not part of those groups, don't realise they need it. This is especially true of the men – for many of them, all they had left was their job and then on weekends when they were home, no services were available. Support services need to realise they must be available seven days a week.

Anne also noted that the stress and trauma following bushfires can mask symptoms of other, more serious diseases.

> We all know we're stressed, so every symptom we have we put down to stress and we don't go and get checked out. It's not just a mental impact, it's a physical impact.

Anne said that humour helped people through the darkest days.

> If you've got a sense of humour, it's a lot easier. But there are times where even the sense of humour fails.

Source: RCVMHS, *Interview with Anne Dixon*, March 2020.

Some experiences of trauma can be particularly harmful to mental health and wellbeing, including experiences such as rape or family violence.[36] Many people across Victoria experience these traumatic crimes, but they are often unreported,[37] sometimes for a fear of not being believed,[38] leaving people to deal with their trauma alone.

Aboriginal people;[39] asylum seekers, refugees and other displaced persons;[40] people who are homeless; children in dysfunctional or violent families, or in various forms of out-of-home care;[41] and people living with a disability,[42] are just some cohorts with a greater likelihood of exposure to trauma. In many cases, their experiences of adversity can lead to further trauma exposures, particularly where children come into contact with the justice system.

Ms Marion Hansen, Co-Chair of the Aboriginal Justice Caucus, told the Commission:

> **Early criminalisation may act as a precursor, causal and aggravating factor for mental illness in children. Criminalisation and incarceration impacts a child's development, whereby compounding mental illness and trauma. Ending the early criminalisation of children is crucial in preventing exposure to practices and experiences that drive poor mental health outcomes. Added to this complexity is that imprisoned children and young people are likely to be exposed to multiple traumatic events, socioeconomic disadvantage, family violence and poor educational opportunities.**[43]

Despite the breadth of potentially traumatic events and circumstances described thus far, it remains difficult to accurately determine the number of Victorians whose mental health has been affected by an experience of trauma. This is in part because not everyone who experiences trauma will go on to experience mental illness or psychological distress.[44] It is also due to broad variation in the ways that trauma is defined and understood.[45] Furthermore, medical practitioners do not routinely screen for trauma,[46] so data is not routinely collected on the number of people accessing the mental health system who have experienced trauma.[47]

However, a large proportion of mental health consumers have experienced trauma in their lifetime. In the population-representative sample of the *National Survey of Mental Health and Wellbeing*, 57 per cent of respondents reported lifetime experience of one or more potentially traumatic events.[48] The former Department of Health and Human Services estimated that as many as 90 per cent of public mental health service consumers have experienced one or more incidents of trauma.[49]

Some international studies examining the prevalence of trauma among mental health service consumers indicated the likelihood of exposure to traumatic events across a consumer's lifetime was as high as 73–98 per cent.[50]

15.2.1 Types of traumatic experiences

The experiences and circumstances that can expose people to trauma and adversity are many and varied,[51] and can be an 'everyday reality' for some communities.[52] The Commission has heard the impact of trauma is typically less related to the event or circumstances that occur, and more related to 'an individual's experience of those events'.[53] Given the variation of individual responses to trauma, the term 'potentially traumatic events' is sometimes used to describe events that may cause trauma.[54]

Figure 15.1 provides a summary of some of the 'types' of trauma that people can experience. With high rates of exposure to trauma overall, and increasing rates of some trauma exposures, a mental health system which understands and can respond to 'the psychological consequences of traumatic events is of highest societal and scientific relevance'.[55]

Figure 15.1: Experiences of trauma

Individual trauma results from an event, series of events, or set of circumstances that are life threatening, or are physically or emotionally harmful.[1] Individual trauma experiences may be direct, that is, directly experienced or witnessed, or indirect, for example, trauma that is vicarious in nature, such as being told or hearing about a traumatic event or series of events, but not being directly exposed to it.[2,3]

> **Trauma can occur in a diverse range of contexts, from early childhood within a family, to trusted family members to external events. The nature of the trauma and the context in which it occurred will have different implications for the ways in which people respond and cope with those difficulties. Therefore, it is important to acknowledge that trauma occurs in a range of ways and while there are some commonalities, there are also going to be some differences in the way people respond to those experiences.[4]**
>
> Dr Brendan O'Hanlon, Mental Health Program Manager at the Bouverie Centre, La Trobe University

Group trauma refers to the experience of trauma shared across a group, such as a family or group of colleagues.[5]

> **In some occupations, such as the police and emergency services, repeated exposure to potentially traumatic events can be an inevitable and unavoidable component of the work. There is evidence of higher rates of mental disorders, self-reported psychological distress and suicidality when compared to the general Australian population. However, there are also some possible protective factors such as the meaning of the job, the training, and an expectation that trauma exposure will be a component of their job. Individuals in these occupations are more likely to experience difficulties where repeated experiences of traumatic incidents result in progressively more severe reactions over time.[6]**
>
> Ms Nicole Sadler, Head of Policy and Practice at Phoenix Australia, Centre for Posttraumatic Mental Health

Sources: 1. Substance Abuse and Mental Health Services Administration, *Trauma-Informed Care in Behavioural Health Services,* 2014, p. 36; 2. *Witness Statement of Nicole Sadler,* 19 June 2020, para. 7; 3. *Witness Statement of Professor Louise Harms,* 23 May 2020, para. 48; 4. *Witness Statement of Dr Brendan O'Hanlon,* 17 June 2020, para. 82; 5. Substance Abuse and Mental Health Services Administration, p. 38; 6. *Witness Statement of Nicole Sadler,* para. 25.

Collective trauma refers to traumatic experiences that disrupt social life and the functioning of many people at once.[7] Collective trauma experiences can overwhelm communities[8] and are varied in nature. Examples include large-scale emergencies (for example, industrial accidents), acts of violence or conflict (for example, war, acts of terror) or natural disasters (for example, bushfires, floods).[9]

> **For people who experience trauma in the context of emergencies or disasters, the destruction is typically not only to individuals and their wellbeing and functioning but also the whole community and collective systems of support. In that sense there is a whole of system failure rather than a failure of a person's ability to regulate and make meaning at an individual level. The second unique aspect is a systemic breakdown of recovery resources – the resources for emergencies and disasters are simply not there in the way they are for a road trauma victim, for example. The situation is compounding, involving multiple traumas simultaneously that are not necessarily the same, if even similar.**[10]
>
> Professor Louise Harms, Chair and Head of Social Work at Melbourne School of Health Sciences, University of Melbourne

Intergenerational trauma describes the persistence or carrying across of trauma over generations. Intergenerational trauma can occur in families through parent–child relationships[11] and may be the result of broader social factors, such as disadvantage or discrimination.

> **Where children "inherit" poverty, trauma or other social disadvantage, they receive and mimic the patterns that they observe in their parents. The impact of trauma or neglect can thereby continue beyond the initial trauma itself. We have seen [for] example that the impacts of trauma on Holocaust survivors can be seen for generations following the events of that period.**[12]
>
> Dr Tim Moore, Senior Research Fellow

Sources: 7. Kate Brady, Agathe Randrianarisoa, and John Richardson, *Best Practice Guidelines: Supporting Communities Before, During and After Collective Trauma Events,* 2018, p. 5; 8. Brady, Randrianarisoa, and Richardson, p. 5; 9. Substance Abuse and Mental Health Services Administration, p. 38; 10. *Witness Statement of Professor Louise Harms,* paras. 41–42; 11. *Witness Statement of Dr Tim Moore,* 2 June 2020, para. 17(c); 12. *Witness Statement of Dr Tim Moore,* para. 35(c).

Figure 15.1 Experiences of trauma *(continued)*

Historical trauma describes events that significantly disrupt, or erode, the culture or heritage of a community.[13] Communities that have experienced historical trauma are often affected by further trauma and/or adversity. Examples of historical trauma in Victoria include experiences of invasion and displacement of Aboriginal Victorians and the experiences of humanitarian migrants.

> **Socio-historical and cultural risk factors such as being members of the stolen generation, and those that have experienced intergenerational cultural losses, such as dispossession of land, and loss of language, ceremony and other cultural practices, and connections to culture - combined with intergenerational poverty and other social disadvantages such as poor access to education and housing – further compounded by alcohol and drug misuse – especially ice use at this time – and family violence, such as physical, emotional and childhood sexual abuse, and neglect – all of this contributes to re-traumatisation. And when you include ongoing experiences of racism, structural inequality and social exclusion that we see in this country, you end up with younger generations who do not see a future for themselves, who do not see themselves represented in the future of this country.[14]**
>
> Dr Graham Gee, Clinical Psychologist and Senior Research Fellow, Murdoch Children's Research Institute

Complex trauma refers to severe trauma experiences that are repetitive, prolonged and cumulative.[15] Complex trauma is often interpersonal, intentional, extreme, ongoing and can be particularly damaging when it occurs in childhood.[16] Examples of complex trauma include physical abuse, sexual or emotional abuse, neglect, witnessing family violence or community violence, as well as medical trauma.[17]

> **From a mental health perspective, complex trauma is a risk factor in adults for serious mental illness (e.g. schizophrenia, borderline personality disorder), high prevalence disorders such as depression, anxiety, eating disorders and substance abuse, recently defined complex [post-traumatic stress disorder] … learning problems, social disruption, interpersonal crisis, socio-economic drift, criminal behavior, and chronic physical health problems.[18]**
>
> Professor David Forbes, Clinical Psychologist and Director at Phoenix Australia, Centre for Posttraumatic Mental Health

Sources: 13. Substance Abuse and Mental Health Services Administration, p. 39; 14. *Witness Statement of Dr Graham Gee,* 10 July 2019, para. 19; 15. *Witness Statement of Indigo Daya,* 12 May 2020, para. 21; 16. *Witness Statement of Dr Robyn Miller,* 7 August 2020, para. 101; 17. Matthew Kliethermes, Megan Schacht and Kate Drewry, 'Complex Trauma', *Child and Adolescent Psychiatric Clinics of North America,* 23 (2014), 339–361 (p. 340); 18. *Witness Statement of Professor David Forbes,* 27 June 2019, para. 23.

Adverse childhood experiences typically refers to trauma or enduring adversity experienced during childhood. Examples of adverse childhood experiences include physical, sexual, and emotional abuse, physical and emotional neglect or witnessing domestic violence as a child.[19] Some definitions of early adversity are broader and include sibling and peer victimisation (for example, bullying) or the death of a parent when young.[20]

> **Given that an infant's primary drive is towards attachment, not safety, they will accommodate to the parenting style they experience. They have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze, fight or flight response.**[21]
>
> Dr Robyn Miller, CEO, MacKillop Family Services

> **Research has shown that adults who were exposed to adverse childhood experiences, such as exposure to maltreatment, witnessing violence, or living with household members with mental illness, are more likely to have poor health and chronic health conditions as adults, even after controlling for socioeconomic and demographic factors.**[22]
>
> Ms Kim Little, Deputy Secretary, Early Childhood Education, Victorian Department of Education and Training

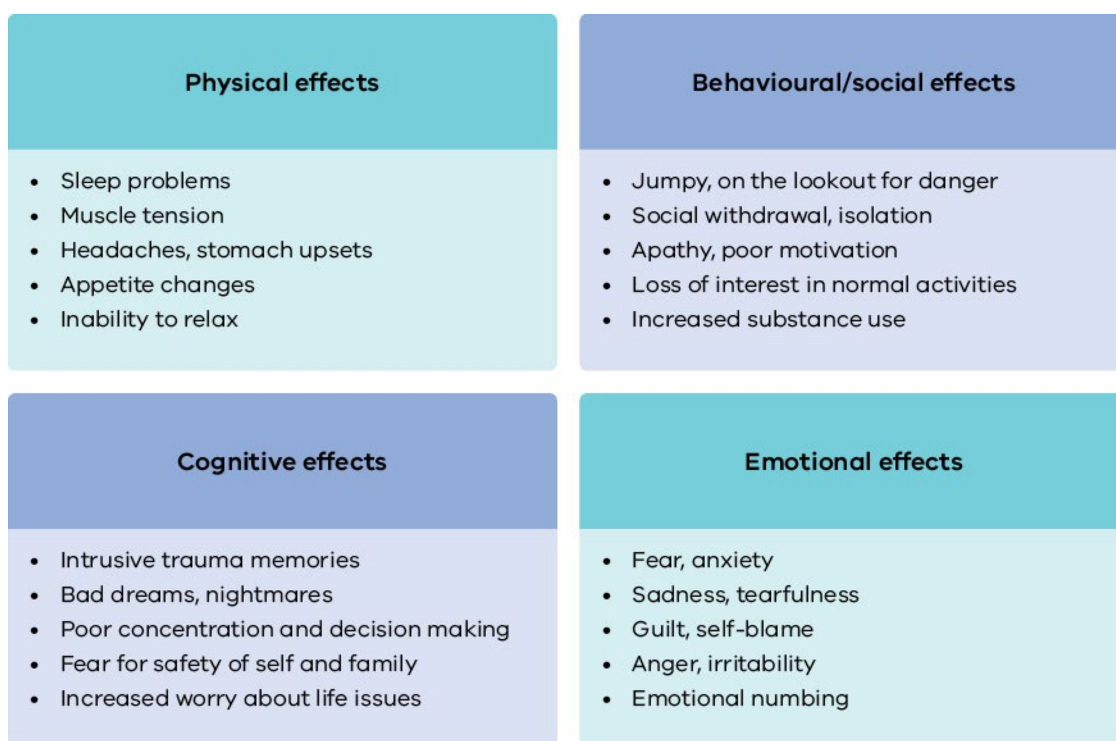
Sources: 19. Vincent J Felitti and others, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults', *American Journal of Preventive Medicine,* 14.4 (1998), 245–258 (p. 248); 20. David Finkelhor and others, 'Improving the Adverse Childhood Experiences Study Scale', *JAMA Pediatrics,* 167.1 (2013), 70–75 (p. 74); 21. *Witness Statement of Dr Robyn Miller,* para. 88; 22. *Witness Statement of Kim Little*, 19 May 2020, para. 19.

15.3 The mental health and wellbeing impacts of trauma

A growing body of evidence indicates a clear link between exposure to trauma and mental illness.[56] Evidence describes the experience of trauma as 'a massive disruption to a person's wellbeing, functioning, coherence and sense of meaning. It also involves a disruption to a person's sense of control, empowerment and agency.'[57]

Research also indicates that there is a broad range of physical, behavioural, cognitive and emotional responses that can occur following exposure to a traumatic event.[58] Examples of each of these are shown in Figure 15.2.

Figure 15.2: Common responses to potentially traumatic events



Source: Phoenix Australia – Centre for Posttraumatic Mental Health, 'What is the link between trauma and mental illness?' Report prepared for the Royal Commission into Victoria's Mental Health Services, 2020, p. 11.

Some consumers experience the responses outlined in Figure 15.2 for long periods of time, with considerable functional impairment (such as a reduced capacity to work, engage in relationships or socialise), but with symptoms that are not sufficient to meet the criteria for a formal mental health diagnosis.[59] This is sometimes referred to as having a 'subsyndromal condition'. Consumers with subsyndromal conditions are often not eligible for[60]—and therefore miss out on[61]—receiving mental health support.

Subsyndromal conditions can have profound impacts on consumers through the experience of 'a degraded quality of life' due to 'a constant background of instability or unhappiness'.[62] Ms Nicole Sadler, Head of Policy and Practice at Phoenix Australia, Centre for Posttraumatic Mental Health, states:

> Sub-syndromal conditions do not meet the diagnostic criteria for a disorder, but can still impact negatively on someone's ability to get on with their family, social, work and interpersonal responsibilities. People may become angry or irritable, abuse substances, drink too much, or undertake risk taking behaviour (e.g., driving too fast, gambling or even risky sexual behaviours). These may be transitory or they may over time develop into mental disorders.[63]

For some consumers, poor mental health and wellbeing outcomes persist following an experience of trauma, and worsen over time. This increases the risk of developing long-term subsyndromal conditions and post-traumatic mental illness.[64]

The most widely recognised mental illness diagnosis following trauma is PTSD. This diagnosis was established following the Vietnam War, when researchers increasingly began to explore and draw links between experiences of combat trauma and poor mental health outcomes.[65]

PTSD was defined in the third (and in subsequent) editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[66] A diagnosis of PTSD requires that the individual has had:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
>
> - Directly experiencing the traumatic event(s)
> - Witnessing, in person, the event(s) as it occurred to others
> - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
> - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, or police officers repeatedly exposed to details of child abuse).[67]

A key limitation of these diagnostic criteria is that some experiences, which are broadly but not technically recognised as being traumatic, are excluded. For example, evidence indicates that 'long-term experiences of adversity such as poverty, extreme inequity and discrimination can also constitute trauma'.[68] Life stressors, such as homelessness, loss of employment, financial hardship or relationship breakdown, are also increasingly being recognised as 'tipping factors' that may contribute to suicidal behaviour and suicide attempts.[69]

Common post-traumatic mental illnesses and examples of their symptoms are described in Table 15.1.

Table 15.1: Common symptoms of post-traumatic mental illnesses

PTSD	• Intrusive memories, dreams • Avoidance of trauma reminders • Persistent hyperarousal (for example, hypervigilance, startle response) • Negative mood and thoughts
Depression	• Depressed mood • Loss of interest in normal activities • Low energy, fatigue • Appetite disturbance, weight loss or gain • Feelings of worthlessness or guilt • Poor concentration • Recurrent thoughts of death or suicide
Generalised anxiety disorder	• Excessive anxiety or worry about several life areas • Restlessness, being on edge • Muscle aches or soreness • Tiredness, fatigue • Poor concentration • Irritability • Sleep problems
Panic disorder	• Rapid onset of intense fear or discomfort • Rapid heart rate, sweating, trembling • Shortness of breath, chest pain • Nausea, dizziness • Feeling detached or 'out of one's body' • Fear of losing control or fear of dying
Substance use disorder	• Hazardous substance use, physical health problems • Damage to interpersonal relationships or functioning • Withdrawal and/or tolerance and/or craving • Restriction of other activities • Repeated attempts to quit

Source: Phoenix Australia – Centre for Posttraumatic Mental Health, *What is the link between trauma and mental illness? Report prepared for the Royal Commission into Victoria's Mental Health Services*, 2020, p. 17.

The mental health and wellbeing impacts of trauma vary considerably. They range from transitory symptoms (e.g. short-term feelings of being unsafe, uncertain or unsettled), to subsyndromal conditions, to the development of chronic and complex mental illness.[70]

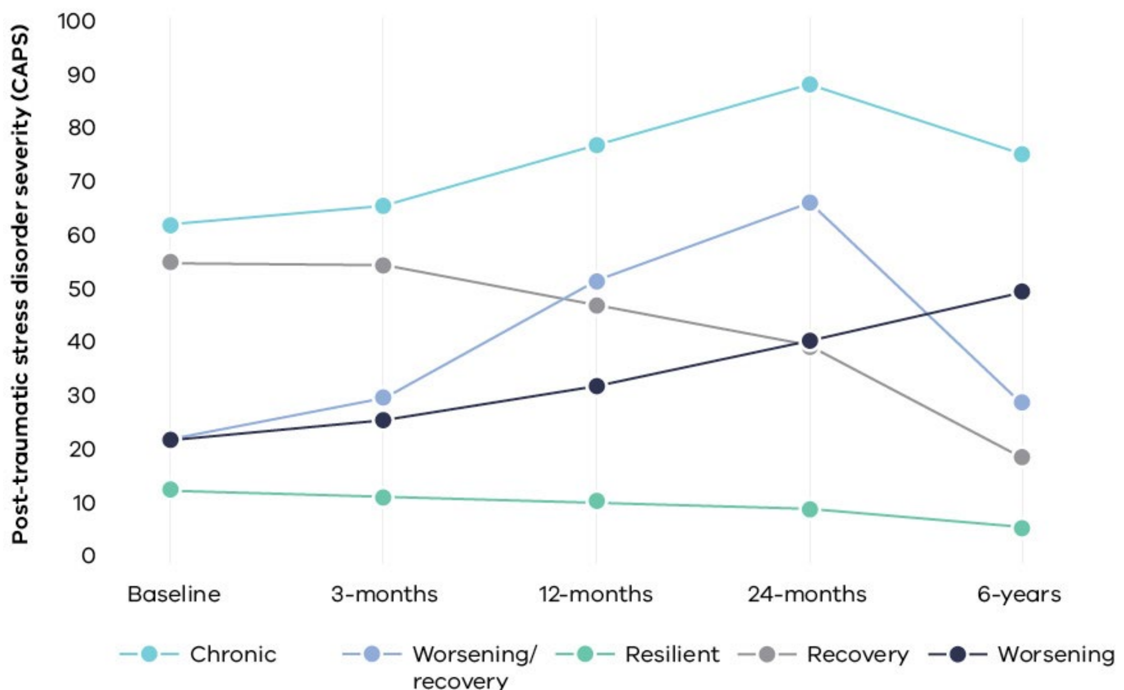
It is clear that the vast majority of people affected by trauma go on to recover relatively quickly, with only a minority going on to experience poor mental health and wellbeing over the long term.[71] To improve understanding of the mental health impacts of trauma, studies have sought to map the varying trajectories of psychological distress and mental illness following exposure to a potentially traumatic event.

One study of 1,084 consumers who were affected by trauma and had a subsequent diagnosis of PTSD, identified five common 'classes' or mental health trajectories the study participants experienced over time. They included:

- a 'resilient' class, where people maintained relatively low levels of PTSD symptoms and healthy functioning across time (73 per cent)
- a 'worsening' class (or 'late onset' class), where people experienced few symptoms at first, which then increased over time (10 per cent)
- a 'worsening/recovery' class, where symptoms initially worsened and then reduced over time (8 per cent)
- a 'recovery' class, where people experienced high levels of symptoms at first, which then reduced over time (6 per cent)
- a 'chronic' class, where people experienced consistently high levels of symptoms over time (4 per cent).[72]

Figure 15.3 demonstrates that not all people go on to develop mental illness following a traumatic event or events,[73] and the psychological impacts of experiencing a stressful or traumatic life event are highly varied in terms of 'valence, duration, and severity'.[74]

Figure 15.3: Trajectories of post-traumatic stress disorder response after traumatic injury



Source: Bryant and others, 'Trajectory of post-traumatic stress following traumatic injury: 6-year follow-up', *The British Journal of Psychiatry*, 206 (2015), 417–423 (p. 420).

Notes: Patients followed five distinct trajectories: a chronic class (4 per cent of all patients), a recovery class (6 per cent), a worsening/recovery class (8 per cent), a worsening class (10 per cent) and a resilient class (73 per cent). CAPS, Clinician-Administered post-traumatic stress disorder (PTSD) Scale for Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Proportions may not sum to 100 per cent due to rounding.

These variations in mental health outcomes and mental illness following exposure to trauma are thought to be due, in part, to the presence or absence of 'moderating factors', which influence a person's risk of, or resilience to, developing adverse mental health outcomes following a potentially traumatic event. Moderating factors include factors present or absent before the event (pre-event factors), during the event (peri-event factors), and after the event has happened (post-event factors). Figure 15.4 illustrates some risk and protective factors for mental health outcomes following trauma.

The 'loading' or accumulation of risk and protective factors is thought to play some part in influencing the likelihood of mental illness developing following exposure to trauma. For example, the presence of protective factors, such as social connection—including support from peers or peer support workers[75]—or the absence of other life stressors, increase the likelihood of recovery from trauma.[76]

On the other hand, greater loading of risk factors, such as pre-existing mental illness or prior trauma exposure, can trigger or exacerbate mental illness.[77] In some cases, loading across moderating factors can be 'so great' that development of a mental illness is a near certainty.[78] For these consumers, the recovery journey is more likely to be long-term and non-linear.[79]

Figure 15.4: Factors which may moderate the mental health and wellbeing impacts of trauma

Sources: *Witness Statement of Professor Louise Newman AM*, 1 May 2020; *Witness Statement of Professor Alexander McFarlane AO*, 14 May 2020; *Witness Statement of Professor David Forbes*, 27 June 2019; *Witness Statement of Nicole Sadler*, 19 June 2020; *Witness Statement of Dr Rob Gordon*, 20 May 2020; *Witness Statement of Dr Sara Renwick-Lau*, 19 May 2020; *Witness Statement of Professor Louise Harms*, 3 May 2020; Jitender Sareen, 'Posttraumatic Stress Disorder in Adults: Impact, Comorbidity, Risk Factors, and Treatment', *The Canadian Journal of Psychiatry*, 59.9 (2014), 460–467; Julia A. DiGangi and others, 'Pretrauma Risk Factors for Posttraumatic Stress Disorder: A Systematic Review of the Literature', *Clinical Psychology Review*, 33.6 (2013), 728–744; Tracey Varker and others, *What Is the Link Between Trauma and Mental Illness? Report Prepared for the Royal Commission into Victoria's Mental Health System*. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne, 2020; Orygen, The National Centre of Excellence in Youth Mental Health, *Trauma and Mental Health in Young People*, 2018.

Personal story:

Catherine White

Catherine describes the impact that trauma has had on her mental health, and said her personal experiences of trauma began during her childhood, but that she had a delayed reaction.

> When someone has been through a traumatic experience, they may not view it as a crisis at the time. However, it's bound to have some effect down the track, particularly when they are confronted with a similar situation.

Around 20 years ago, Catherine landed her perfect job. Not long after she started, she was subjected to severe bullying and sexual harassment in the workplace, which impacted her mental health and led to her experiencing extreme anxiety and fear. Catherine started regularly drinking alcohol and eventually resigned from the role.

> I just fell in a heap. My coping mechanism for any stress was alcohol. I was binge-drinking for nearly seven years.

After deciding that she needed help, Catherine booked into a rehabilitation program at a private clinic.

> I was lucky because I had private health insurance and the money to be admitted to a rehabilitation program. It's a huge decision to seek that help when you are dealing with so much humiliation and shame.

Following rehabilitation, Catherine experienced a relapse and saw a psychologist who diagnosed her with post-traumatic stress disorder (PTSD).

> I felt a bit relieved after receiving that diagnosis because I had something to work with. I was not someone who had just gone onto alcohol, it was symptomatic of something else.

Catherine said that at the time, dual diagnosis was new and not many people drew the connection between trauma, mental health and addiction. She says that after her PTSD diagnosis, she was still drinking alcohol.

During the second phase of her recovery journey, Catherine found a GP who understood addiction and mental health, and the linkages between the two.

> I was referred to a GP who is an angel. She has offered me so much empathy, compassion and support without any judgement.

Catherine doesn't believe a person's recovery journey has an end date and says it's not necessarily a linear process. She calls it a 'staggered process' of recovery.

> Recovery requires looking at all aspects, taking a holistic approach of a person's life and putting in place a range of safety nets and supports so that if one falls over, the person can sort or lift themselves up with another.
>
> For me, recovery is about making sure I feel safe, reviewing relationships in my life and about having purpose to my pain.

Source: *Witness Statement of Catherine White*, 2 July 2020.

15.4 Groups at greater risk of developing trauma-related mental illness

Research on moderating factors (described in Figure 15.4) indicates that some experiences of trauma increase the risk of mental illness developing; it also suggests that exposure to severe forms of traumatic events and circumstances is not evenly distributed across populations. Exposure to traumatic events that are repetitive, prolonged and cumulative are more likely to result in ongoing mental health challenges or mental disorders, especially if the trauma was related to intentional acts of harm.[80]

15.4.1 People exposed to repeated traumatic events or prolonged adversity during childhood

People exposed to repeated traumatic events or prolonged adversity during childhood are at increased risk of developing mental illness.[81] In particular, experiences of sexual abuse, violence and neglect, over a prolonged period, and perpetrated by someone in a position of trust, are more likely to result in mental illness.[82]

The link between adversity and mental illness has been demonstrated most comprehensively in the field of childhood experiences of adversity. One international researcher stated, 'the evidence of a link between childhood misfortune and future psychiatric disorder is about as strong statistically as the link between smoking and lung cancer'.[83]

Trauma and adversity experienced in childhood diminishes 'sense of safety, stability and wellbeing' and, if it continues over long periods of time, the impacts are 'profound and exponential'.[84] The link between childhood adversity and cumulative, long-term harms experienced during childhood, adolescence and adulthood, was noted in a seminal American study, which found:

> a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Disease conditions including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, as well as poor self-rated health also showed a graded relationship to the breadth of childhood exposures. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative.[85]

Research suggests that children display distress in different ways depending on their age, developmental stage and the quality of care they receive. For example, some children are 'more likely to show externalising behaviours like aggression', and other children are more likely to experience 'internalising symptoms such as depression or anxiety'.[86] When unaddressed, trauma is more likely to lead to other issues, such as 'pre-teen illicit drug use (including pre-teen heroin use), childhood homelessness (including running away from "home"), criminal behaviour in childhood and adulthood, incarceration and early school leaving.'[87]

In Victoria, children who have experienced adverse life circumstances, including those in contact with Child Protection and who have experienced out-of-home care, often 'fall through the gaps in government service systems, leading to flow-on effects for mental wellbeing, coping, capacity and other life outcomes that affect social and economic participation'.[88]

15.4.2 People exposed to repeated traumatic events or prolonged adversity during adulthood

People exposed to repeated traumatic events or prolonged adversity during adulthood are also at increased risk of developing mental illness.[89] This includes people who work in some occupations, which, by the nature of the work means that they are commonly exposed to traumatic events or recounts of traumatic events.[90]

Other examples include adults who experience family violence, or people with humanitarian or refugee backgrounds who have experienced torture, war or displacement.[91] These experiences of trauma often occur 'without protective factors in play' (such as access to social connections and family support).[92] Adults who experience repeated and prolonged trauma are more likely to have endured trauma during childhood,[93] illustrating the cumulative and lifelong harms that trauma can inflict.[94]

The Royal Commission into Institutional Responses to Child Sexual Abuse illustrated how the failure of mental health services to recognise and respond to trauma can contribute to the lifelong consequences of trauma and adversity:

> There are consequences for receiving poor or ineffective treatment. For children who have experienced sexual abuse, there is a risk that poor treatment will result in chronic symptoms that follow them into adulthood and make them more vulnerable to further victimisation over their lives. We also heard that inappropriate or ineffective treatment may lead adult survivors to blame themselves for treatment 'failure' or see themselves as broken and unable to recover. Ineffective treatment can undermine recovery if victims lose hope and disengage from support systems.[95]

Professor Dan Lubman, Executive Clinical Director of Turning Point, Eastern Health and Professor of Addiction Study and Services, Monash University, speaking in his personal capacity, pointed out that consumers who have experienced complex trauma may go on to develop other comorbid conditions:

> Alcohol and drugs are commonly used by Australians to help cope with stress, anxiety, pain and insomnia. They are also powerful emotional analgesics, and for Victorians who are victims of trauma, are a common way to help them deal with the significant accompanying mental distress. Research exploring self-medication among people with mental illness have identified dysphoria, anxiety and boredom as major drivers of continued alcohol and drug use, as well as helping to cope with emotional and psychosocial problems associated with their illness—for example, family conflict, trauma, financial problems, lack of vocational opportunities and social isolation. Such findings highlight the need for a multifaceted treatment approach in supporting Victorians with co-occurring mental illness and substance use disorders, as many of these underlying drivers will need to be addressed for treatment to be successful.[96]

15.5 Ways in which consumers access mental health support for trauma

For many people, the mental health and wellbeing impacts of trauma are transitory. In most cases, distress reduces in the days and weeks following the traumatic event, through individuals drawing on their own coping strategies and networks of support.[97]

Where further support is required, some consumers will seek out primary care services, such as GPs.[98] This level of support is adequate for many consumers. Dr Renwick-Lau told the Commission that while some consumers affected by trauma may not require regular or long-term care, it is critical that care is available when consumers want to engage in treatment:

> **Often people present to us with anxiety or personality issues, but actually what they're dealing with is a significant trauma they have suffered previously. In those circumstances, the only people that can provide adequate mental health care are long-term face to face mental health care providers of care for the community—trauma cannot be resolved in the short term. Care does not necessarily need to be regular for years, but to be available at times when patients are in crisis or at a point where they are able to engage in treatment.**[99]

GPs also play a critical role in supporting consumers to become aware of and gain access to additional supports for their mental health.[100] Consumers who are experiencing chronic or worsening mental health following trauma may require more intensive levels of treatment, care and support to match their needs. This may include referral to a clinical psychologist or other secondary care mental health services that have a focus on trauma.[101]

However, a lack of clear, coordinated pathways limits the ease with which primary care providers can navigate support options or refer consumers impacted by trauma to further supports.[102] Dr Mariam Tokhi, GP at DPV Health, speaking in a personal capacity, explained the challenge of supporting consumers to access further treatment, care and support for trauma:

> **There's a lack of trauma-informed psychological support services in the mainstream system. There is also the segmentation of trauma services away from other mental health services. There are some really specialised services, but we do need that understanding of trauma in the broader mental health system.**[103]

Enhancing the ease with which GPs can facilitate access to supports that match the needs of consumers is a core feature of the reformed mental health and wellbeing system, as outlined in Chapter 8: *Finding and accessing treatment, care and support*.

The ways in which consumers access more intensive support for trauma differ to how other mental health consumers access support. Currently, there are relatively few options for trauma support in Victoria, and eligibility criteria limit consumer access to treatment, care and support.[104] Consumer eligibility for secondary care for trauma is typically based on criteria such as personal background (for example, age or citizenship), the nature of the traumatic experiences (for example, the nature of the event)[105] or mental health diagnosis (for example, PTSD).[106]

In the context of trauma, there are three broad pathways by which consumers usually receive mental health support:

- third-party or industry-funded recovery services
- trauma specialist services
- the public mental health system.

15.5.1 Third-party or industry-funded recovery services

Some consumers qualify for trauma recovery services that are covered by a third-party (such as insurance cover). In some circumstances, certain industries or employers fund recovery supports where a traumatic event has occurred. Examples include some occupations (such as the military or first responders), settings or circumstances (such as road traffic accidents), and criminal events (such as victims of crime). Under such circumstances, consumers typically have access to comprehensive,[107] 'good quality' care for trauma-related mental illness.[108]

Even in these circumstances, compensation-based services (that is, services that are funded by a third-party) are required to establish that the consumer has a post-traumatic diagnosis, such as PTSD, in accordance with the DSM guidelines. The consequence of this 'gatekeeper' function[109] is that many consumers presenting with poor mental health who do not meet the criteria for a diagnosis (such as subsyndromal conditions) are excluded from receiving support.[110] This exclusion can exacerbate the experience of trauma for the consumer, family, carers and supporters.[111]

The Commission recognises that many sectors, such as first responder and veteran services, have made substantial efforts to provide and embed support systems for people exposed to trauma at work. However, evidence suggests that addressing the mental health impacts of workplace trauma remains an important area for reform.[112]

15.5.2 Trauma specialist services

Some consumers who are impacted by trauma will qualify for trauma specialist services. Examples of trauma specialist services in Victoria include trauma services for refugees and asylum seekers, sexual assault services, family violence services, child welfare services and women's refuges.[113] These services typically provide a range of recovery supports to consumers, and in some cases, families, carers and supporters, to support healing from particular types of traumatic experiences.[114]

Sometimes referred to as trauma-specific services, these organisations often offer services or programs designed to 'treat and ameliorate' the symptoms and presentations of trauma.[115] Many trauma specialist services have evolved and developed through consumer advocacy, philanthropy and community efforts. As such, trauma specialist services are typically structured in response to a specific trauma type or trauma-related mental health diagnosis.

Trauma specialist services recognise the broad and detrimental impacts trauma can have on people,[116] and typically offer a range of clinical, non-clinical and wellbeing services to support recovery.[117] These services tend to offer a nurturing environment and focus on providing a deep level of understanding and validation for consumers, through the delivery of supports tailored for particular trauma types and events (such as sexual assault services).[118] These service features contribute to effective trauma recovery.[119]

The Commission is aware of significant demand and long wait lists for trauma specialist services.[120] Foundation House, a trauma specialist service for people who have experienced torture and are from migrant backgrounds, noted at one point during the Commission's period of inquiry that there were more than 300 individuals and families on its wait list.[121]

In some instances, trauma specialist services have responded to high demand by building the capacity and capability of the broader mental health system; for example, by offering and conducting education, training, consultation and program development to primary care providers. Many trauma specialist services have also developed collaborative partnerships to deliver consumer-centred care. These practices are described in the Foundation House case study.

Innovative and collaborative partnerships between mental health and wellbeing services in the new mental health and wellbeing system are described in Chapter 5: *A responsive and integrated system*.

Case study:

The Victorian Foundation for Survivors of Torture (Foundation House)

The Victorian Foundation for Survivors of Torture (Foundation House) is a specialist refugee trauma service supporting survivors of torture and other traumatic events. It has a diverse client base and supports people arriving in Australia through the Humanitarian Program or as asylum seekers. On average, Foundation House assists more than 4,000 clients from around 40 different countries and ethnicities each year.

Paris Aristotle AO, the CEO of Foundation House, said the agency has developed an integrated trauma recovery service model that captures the principles of trauma-informed care. It presents the recovery goals for clients that guide the agency's work as being to restore:

- safety and enhance agency and control
- secure attachments, promote connections to others and enhance the sense of belonging
- meaning and purpose to life, rebuild identity and promote justice
- dignity and value and reduce excessive shame and guilt.

Mr Aristotle said the agency also uses a trauma-informed approach to help refugees to recover from torture and other traumatic events by providing treatment, care and support to reduce symptoms characteristic of post-traumatic stress disorder and other common disorders such as anxiety and depression.

> We provide a wide range of psychosocial services including mental health services in the form of trauma counselling and psychotherapy, psychiatric care, natural and tactile therapies and community capacity building programs.

Mr Aristotle noted a trauma-informed approach is also about supporting staff within the organisation who hear the traumatic stories of their clients.

> We need to support how our staff manage and deal with the content of the work and the impact it can have on them personally because to connect is to feel. It is not simply a matter of them switching that off at some point at the end of the day. Organisations need to be focused and respectful and have clear frameworks for their clients, and the communities that they are engaging with, as well as for the people within the agency.

Photo credit: Annette Ruzicka Photography, courtesy of Foundation House, 2018

Mr Aristotle said Foundation House leads several programs designed to improve the capacity and responsiveness of other sectors and systems, such as primary health and mental health services. This work is performed through the 'Foundation House framework'.

> Externally, the Foundation House framework is used to support other organisations and service providers to develop their capacity to work with survivors of torture and other traumatic events in a trauma-informed way. This is achieved through our professional development, secondary consultation and consultancy services and other collaborative approaches, and production of resources such as a guide to working with refugee young people and guides for GPs and other primary health workers.

Kylie Scoullar, General Manager, Direct Services at Foundation House, said the organisation works to foster partnerships with different service providers. Ms Scoullar said that collaborative approaches can facilitate better outcomes for consumers.

> Collaboration between Foundation House and mental health providers (such as the Child and Adolescent Mental Health Service in Victoria (CAMHS)) has helped some of our clients to overcome stigma and receive treatment. That has been achieved by, for example, arranging for the client to attend CAMHS sessions at Foundation House (along with their trusted Foundation House counsellor), which is an environment they are comfortable with.

Source: *Witness Statement of Paris Aristotle*, 30 June 2020; *Witness Statement of Kylie Scoullar*, 16 July 2019; Foundation House, Webinar Recording: Online Launch of "Rebuilding Shattered Lives 2nd Ed." by Dr Ida Kaplan, <vimeo.com/489148532>, [accessed 14 December 2020].

15.5.3 The public mental health system

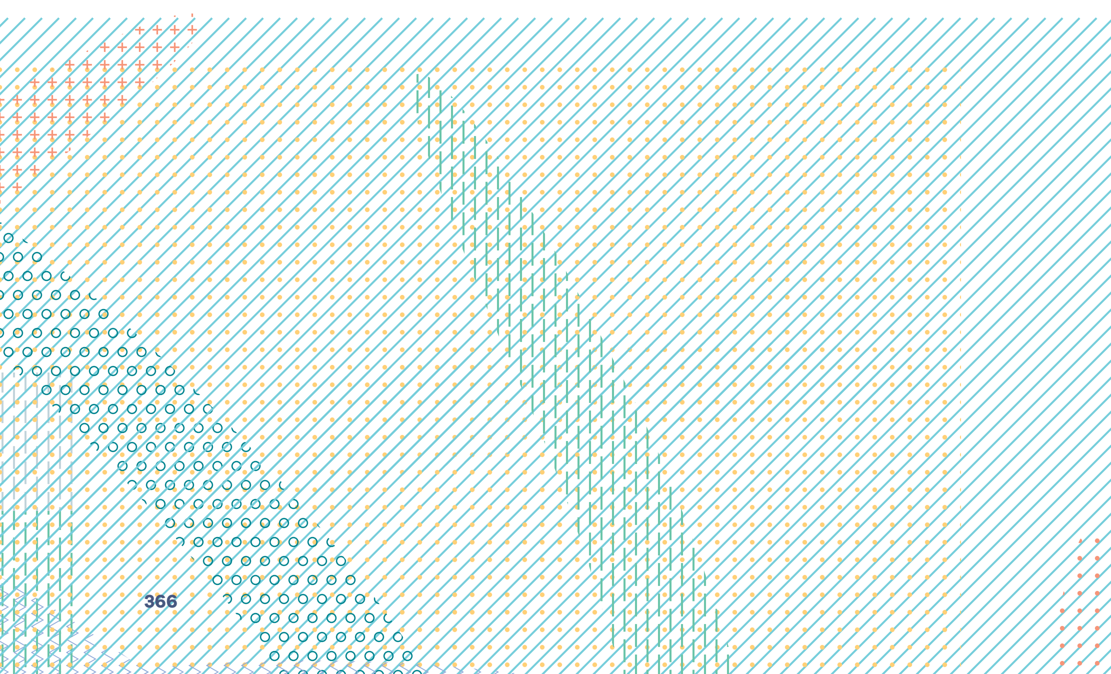
Some people who have experienced trauma can access support from the public mental health system. Consumers may access the public mental health system by choice; if they cannot afford private health services; or if they do not meet the eligibility criteria for trauma specialist services or third-party or insurance-funded supports. Regardless, consumers supported by the public mental health system do not always have the benefit of a specialised or 'systematic approach to their care and support'.[122]

Evidence indicates that the public mental health system does not adequately identify or provide for the mental health and recovery needs of consumers affected by trauma. Professor David Forbes, Clinical Psychologist and Director at Phoenix Australia, Centre for Posttraumatic Mental Health, told the Commission:

> A key issue ... is that public mental health tends not to provide services for trauma related mental health problems. Community mental health services and public psychiatric hospitals focus more on conditions referred to as serious mental illness such as schizophrenia, bipolar disorder and a range of other psychoses, severe borderline personality disorder or severe depression with suicidal intent. Therefore they do not offer a community treatment option for those with serious high-prevalence trauma-related disorders such as PTSD.[123]

The lack of support available in the public mental health system for people affected by trauma results in consumers experiencing deteriorating mental health, and only gaining access to support when they reach crisis. In a trauma roundtable hosted by the Commission, a participant stated:

> if we were trying to get somebody into a hospital setting, on the basis that they had a trauma-based condition ... they wouldn't even get through the door unless they presented ... as being psychotic. They remain struggling with their trauma for long enough to the point where they became so ill they were either suicidal or psychotic, they might then get into the system. And so the notion that trauma is even dealt with in those arrangements ... is a funny one.[124]



15.6 Limitations of the current mental health system's response to trauma

There are many challenges and barriers which limit the mental health system's ability to recognise and respond to the needs of consumers who have experienced trauma.

15.6.1 Inconsistent service responses for consumers affected by trauma

There are many examples of mental health services across Victoria that recognise, and respond to, the needs of consumers affected by trauma.[125] Some consumers shared with the Commission positive experiences of being supported by mental health workers who provided therapeutic,[126] holistic care,[127] and who coordinated other services to assist their recovery from trauma.[128]

These practices are more common in services that employ a trauma-informed approach—involving the creation of 'environments and relationships that promote recovery and prevent retraumatisation'.[129] These organisations routinely educate and train staff to recognise and respond to consumers impacted by trauma and support their staff to prevent and manage experiences of vicarious trauma.[130]

Currently, trauma-informed settings and services exist in isolated pockets of the mental health system and are not available at a system-wide level for all consumers.[131] This has caused siloed and segmented[132] trauma expertise across the mental health system, and reinforced disparate and inequitable service offerings to consumers impacted by trauma (as described in section 15.5).

The mental health system has evolved without creating clear pathways or facilitating communication between services,[133] posing difficulties for consumers to access support for trauma.[134] As Professor Louise Newman AM, Professor of Psychiatry at the University of Melbourne and Practising Perinatal and Infant Clinician, stated, 'while there is a clear, evidence-based relationship between trauma and mental health' it is a 'fundamentally undertreated area'.[135]

Case study:

Latrobe Regional Hospital

Latrobe Regional Hospital (LRH) is the main provider of mental health services across Gippsland, offering a broad range of services including inpatient, community residential, and prevention and recovery care. LRH cares for a community of more than 260,000 people, many of whom have experienced a traumatic event or series of events, for example, bushfires and the Hazelwood mine fire, which has led to or exacerbated poor mental health.

Staff at LRH observed high numbers of young people whose mental health had been affected by traumatic or adverse events in their early development. Based on this, along with significant research indicating the impact of trauma neurobiologically and the need for ongoing management, it was determined that trauma-informed practice should be integral to the mental health services they provide in their community.

Ms Cayte Hoppner, Executive Director of Mental Health and the Chief Mental Health Nurse, said LRH has implemented a model of trauma-informed care driven by a new model of education for staff focused on 'a change in language and how we work differently with people'.

> We started asking 'what has happened to you?' rather than 'what is wrong with you?' and asked how we can support them through the service system. The training recognises that it could be retraumatising coming into the system to seek help.

All staff are involved in the training, including nurses, reception and other hospital staff (for example, cleaning staff), in recognition that a person can be retraumatised by their first point of contact with a service, if that contact does not consider the trauma history of the person. LRH has also adopted processes that enable staff to reflect on their approach to trauma-informed practice, to encourage them to stay committed to it. Further, to ensure that trauma is considered in all contexts, the training is embedded into more specialised staff training modules run by LRH.

Ms Hoppner explained that LRH's lived experience workforce was critical to developing the training and was involved at every step.

> Lived experience groups have strong links with our education and training unit, plus our training development and service delivery. The voices of those with lived experience are valued in our ongoing structure.

Ms Hoppner said LRH did face challenges in implementing the trauma-informed approach, as there are large geographic distances between the services it provides.

Photo credit: Latrobe Regional Hospital

> We have a large number of sites so ensuring that the learning and understanding was consistent was hard. We also worked to develop a trauma-readiness guide that any service could use in the region. We wanted the practice and approach around language to be the same across all services.

Initially, it was also challenging to convince everyone of the need for practice change.

> A key challenge was some staff groups thought it wasn't relevant to them, but when they attended the training they found it particularly rewarding.

An initial evaluation has noted the success of the training, but Ms Hoppner said the hospital is now reviewing the experiences of five consumers per month to assess progress and benefits.

> We know our training is right, but sustaining the practice change is the hard part. It's what we need to concentrate on now to translate better outcomes for patients. Reviewing records and talking with consumers will provide us the qualitative feedback to help us improve.

Ms Hoppner noted that further success can be achieved by extending the trauma-informed approach 'beyond the education framework into the policy and procedure environment', such as human resource practices and organisational governance, and by ensuring management across the organisation is engaged in the approach.

LRH is now working to extend the reach of the training to other services across LRH and to embed it further within its training program.

Source: RCVMHS meeting with Latrobe Regional Hospital, 11 June 2020; Latrobe Regional Hospital, About us, <www.lrh.com.au/about-lrh/organisational-information/about-lrh>, [accessed 29 June 2020].

15.6.2 Failure to recognise the impact of trauma on mental health and wellbeing

The predominant biomedical model of mental health—on which the mental health system was founded—typically seeks out genetic, biomedical and neurodevelopmental origins of mental illness, and focuses on diagnoses and medicalised responses, such as medication.[136] For some consumers, a diagnosis of mental illness[137] and the use of medication can be beneficial.[138] For others, this approach can be harmful.

Ms Daya described her experience of mental health services:

> no space or effort is made to frame people's experiences as meaningful responses to what has happened in their lives. Emotional distress and trauma is stripped of meaning and reduced to diagnostic labels, treated with pills and force, which can render these significant life experiences as largely meaningless.[139]

In mental health practice, the biomedical model focuses on mental illness generated by the individual's 'brain, genes or personality structure'.[140] An outcome of this has been that the mental health system has neither been encouraged nor required to routinely screen for trauma.

Witness, Ms Elizabeth Porter, described supporting a friend during an admission to a public hospital:

> As another example, a friend has Dissociative Identity Disorder. She had recently had a prolonged suicidal crisis and was getting picked up by the police or the [crisis assessment and treatment] team, going to hospital and getting discharged after less than 24 hours. Then the situation would repeat. She told me that they kept discharging her, telling her that she was acting out; being childish; and wanting attention. She was profoundly distressed and suicidal, in a high-risk situation with impulsive and dangerous behaviours. In my view the public mental health system didn't have the faintest idea how to respond to her. The public hospital also did not elicit the source of her distress, which was that she was going through civil court hearings related to childhood sexual assault. It was obvious to me after talking to her for twenty minutes that her suicidality was a trauma response.[141]

The Commonwealth Government's *National Practice Standards for the Mental Health Workforce* requires 'mental health practitioners to take into account experiences of trauma at points of access to the service and to conduct and document a comprehensive, trauma-informed assessment.'[142] However, there are significant barriers to mental health practitioners applying or utilising screening or assessment tools in mental health settings.[143]

In one study of youth mental health services, it was found that clinicians encounter the following challenges in screening for trauma:

- 'a fear of opening 'Pandora's box' and the clinicians' actual or perceived lack of capacity to respond therapeutically
- concern that asking about trauma could retraumatise or trigger psychological distress
- a belief that treatment for trauma is something that should be provided separately to the mental health care being provided, and is outside the remit of the clinician's role
- issues surrounding disclosure, such as a reluctance to discuss the experience', which may be because of issues of stigma and shame or because the individual involved does not identify the experience as traumatic.[144]

While the concept of trauma-informed practice is now better understood, its application has not necessarily resulted in any appreciable change for consumers across the system.[145] Research describes a 'corresponding anxiety' among clinical staff in enquiring about trauma, due to fear or concern that discussing difficult, distressing and dangerous events may overwhelm both consumers and themselves.[146] This minimises the degree to which trauma is recognised and screened for. Currently, the mental health system largely relies on consumers to disclose their experiences of trauma,[147] despite evidence suggesting that consumers rarely 'spontaneously disclose' trauma.[148] As previously discussed, this is likely to be for several reasons, including low individual readiness to talk about trauma,[149] a lack of trust of services,[150] or fear of not being believed by services.[151]

15.6.3 Lack of therapeutic support for trauma

Evidence before the Commission describes how consumers who have experienced trauma 'cycle in and out of',[152] 'move between'[153] and get 'bounced between'[154] services, without receiving coordinated, therapeutic care for their trauma. Consumers have asserted that recovery from trauma is about much more than finding a 'cure' for their distress or mental illness; rather, it is about 'creating a life worth living'.[155] It requires service responses that are flexible, responsive, continuous and long-term.[156]

Trauma-informed services require an environment that reduces arousal caused by trauma (for example, hypervigilance or stress reactions),[157] and which fosters a sense of safety and trust.[158] Trauma-informed services also recognise the importance of personal relationships,[159] and enable genuine conversations which promote connection and reduce the risk of self-harm.[160] However, such service delivery responses are not supported in the current mental health system as a matter of course.[161]

Responding to trauma requires a holistic understanding of the ways in which the traumatic experience has affected a person's life.[162] This includes whether trauma has caused or exacerbated the mental health issues and if it is impeding recovery.[163]

Ms Rachel Bateman, Witness, stated:

> Often, when we are presented with people who are struggling, our response is to give them therapy (sometimes not good therapy) or medication. But we don't really look at the bigger picture of what else they might need in their life to sustain their wellbeing and find value in life. It might be that they need help to find a hobby, to join a group somewhere, or to volunteer for something. Community supports need to look more carefully at the bigger picture of people's lives.[164]

Wellbeing supports, such as those that foster 'having a job, forming friendships, finding a house and feeling better about yourself', are important for improving and maintaining mental health.[165] They can help consumers improve the quality of their life, reduce stress and improve wellbeing.[166] They can also help consumers to recognise and manage situations that cause episodes of poor mental health.[167] Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services,* outlines how wellbeing supports (such as supports for community connection and social wellbeing, building life skills, securing and maintaining housing, and education, training and employment supports) will be integrated in the future mental health and wellbeing system.

For consumers experiencing chronic or worsening mental health outcomes, clinical supports may be required. Evidence-based trauma treatments[168] (including psychotherapy and medication)[169] can be beneficial in supporting recovery from all types of trauma experiences.[170]

To ensure the provision of clinical and non-clinical services, communication within and among service providers is essential to support consumers affected by trauma.[171] However, collaboration to deliver clinical and non-clinical supports is limited in the current mental health system.[172] Mr Michael Struth, Senior Clinical Lead Mental Health, Western Victoria Primary Health Network, stated in a personal capacity during a roundtable discussion:

> I think the idea of assessing for diagnosis rather than understanding the person seeking help, and the context in which you're seeking help, limits the responses of services. And if they become demand driven … rather than genuine and providers of combinations of treatments that resonate with a person in their experience in a recovery-oriented way, then we will continue to fail to make a difference in the space …[173]

The Commission concurs with findings from the Royal Commission into Institutional Responses to Child Sexual Abuse, and the Royal Commission into Family Violence, which identified the need for a trauma-informed mental health system that readily recognises and responds to trauma, as well as greater coordination across service systems.[174] Responding to the mental health impacts of trauma requires the provision of therapeutic care. In the context of trauma, this includes facilitating access to evidence-based clinical trauma treatments (such as medication[175] or psychotherapy),[176] as well as a range of wellbeing supports.

This was emphasised by Mr Patrick Lawrence, CEO of First Step, who noted that the need for both clinical and non-clinical service provision is crucial to support recovery from trauma. Mr Lawrence described the benefits of the operating model employed by First Step to provide both clinical and non-clinical support:

> One of the great advantages of having a team with both clinical staff and non-clinical staff is that formal diagnoses (for example, for a mental illness) can be balanced with a broad understanding of a person's capacity and psychosocial wellbeing. An over-reliance on a formal diagnosis (for example, by determining treatment on diagnosis alone) can be as inhibiting of progress as the lack of any diagnosis at all, because every person is far more individual and complex than a mere diagnosis would allow. Balancing the clinical with the non-clinical is the best way to achieve a client-centred approach, achieve buy-in from the client, and to plan and implement their treatment.[177]

15.6.4 Failure to provide early support to consumers affected by trauma

The mental health system does not provide early support for people affected by trauma. In discussing the impacts of trauma that occurs early in life, a practitioner from a child welfare agency described to the Commission that there are 'missed opportunities like you would not believe' to intervene earlier for children living with adverse childhood experiences.[178] An absence of early support can compound mental illness and affect consumers, families, carers and supporters.

Witness Ms Erin Davies shared her experience of supporting her son, Matthew, who has autism spectrum disorder (ASD):

> The system does not prioritise prevention or early intervention at a population level. Matthew has ASD, which is not preventable. However, the mental ill-health that has come from his ASD, and exacerbates his experience of it, could have been reduced if there had been earlier intervention.[179]

There is a lack of inpatient and outpatient care directed to those experiencing worsening mental health following trauma. Capacity issues,[180] severity of presentation[181] and systematic barriers (such as referral processes),[182] impede voluntary admissions to inpatient settings. This makes it difficult for these consumers—and their care teams—to find supports to prevent crisis episodes of mental illness.[183]

Failure to provide early support for trauma can result in an 'accrual of problems',[184] including increased risk of mental illness and substance use disorders, chronic physical diseases and relationship breakdowns.[185] Failure to provide early support for trauma, plus the addition of social or cultural determinants of health, can result in a 'cascade' of complex problems[186] that can compound intergenerationally.

This requires a mental health workforce that is highly skilled to understand and support consumers who have been exposed to highly complex traumas. In its submission to the Commission, Djirra (an Aboriginal community-controlled organisation) stated that:

> They [non-Aboriginal psychologists] think they understand trauma but they are very insulated so they don't really. They might be counselling someone for family violence but they don't recognise that generation after generation of your family were removed and that impacts you too. And that family violence is generational. A mother's experience of family violence will echo her own mother's experience, and that will impact her daughter's experience of family violence and her ability to seek help. It's not just that you've been told the stories, you've witnessed it too. It's incredibly complex PTSD.[187]

It is the Commission's position that in order to achieve better mental health outcomes for people who have experienced trauma, greater coordination between the mental health system and other service systems is required to facilitate early support.[188]

15.6.5 Crisis driven access to support for trauma

The failure to provide early support for trauma results in a greater volume of crisis-driven presentations. This is supported by research documenting high rates of consumers with histories of trauma in acute mental health settings in Australia.[189] Studies also suggests that deinstitutionalisation has increasingly narrowed the focus of mental health nurses to 'safe containment' of consumers at the expense of a broader exploration of underlying issues.[190]

The Commission has heard accounts of consumers presenting to acute mental health services in a state of crisis. Often, the consumer's mental health has deteriorated and they use alcohol or drugs[191] as a way of coping with distress from trauma.[192] Delay in receiving mental health support makes treatment and recovery more difficult.[193] In acute settings, treatment is prioritised through assessment of risk or harm to self, as well as the potential risk of harm to other people.[194] As Professor Lubman explained:

> the mental health system is focussed on supporting consumers with mental illness who are at serious risk of harm to themselves or others, and as a result need to exclude other consumers who are not deemed to meet these criteria.[195]

Critically, consumers with deteriorating or episodic mental illness often only receive access to therapeutic recovery supports through acute admission.[196] This is illustrated in Greg's personal story.

Personal story:

Greg

Greg* is an artist who experienced childhood trauma. He spent 10 years self-medicating with alcohol and explained that his work as an artist helped him to manage his trauma.

Greg said that while many people supported him, the arts industry can be quite isolating.

> There is not a lot of help for people in the arts, especially to talk to. In my world you're dealing with a lot of ego, so fragility is not really a thing you show.

Greg said that lockdown as a result of COVID-19 initially brought him a welcome break and allowed him to spend time with his family.

> I got to rest my head from struggling from job to job and continually creating things.

However, Greg found it intensified his tendency to think negative thoughts and to catastrophise, and he was 'beating [himself] up about productivity and not working enough.'

Greg recently experienced an acute admission to hospital, which he attributes to his childhood trauma and 'a perfect storm of all this awful stuff going on in my head and feeling useless'.

> It wasn't just due to the lockdown, it was all sorts of stuff. It was childhood trauma, a lack of love and friendship and loss, generally feeling pretty useless.

Greg's admission facilitated access to the acute care team and cognitive behavioural therapy (CBT), which he has found particularly helpful in giving him clarity about how he feels. Greg's treatment team are now responding to his underlying trauma experience.

> The CBT has just been incredible, and everything that was offered to me by the acute care team. They were just incredible, they kept ringing, they kept in contact, they were just the best.

Greg said that access to CBT through his acute admission has helped him get back on his feet, and he is now feeling positive about life.

> Thanks to my psychologist, my family, I feel like I'm in charge of stuff. I work every day, properly. I'm not beating myself up about wasting time, which I think a lot of people have done.

Source: RCVMHS, *Interview with 'Greg'* (pseudonym), July 2020.

Note: *Name has been changed to protect privacy.

15.6.6 Experiences of trauma within the mental health system

For some consumers, interaction with the mental health system has caused trauma or worsened the impacts of pre-existing trauma, rather than facilitated recovery.[197] This can begin at the outset of a consumer's attempt to access mental health treatment, care and support, where a consumer may have to retell traumatic or painful personal stories several times before receiving assistance.[198] Harm may also be caused if consumers are not believed, or have their stories minimised or avoided.[199] Consumers can also be traumatised from witnessing or experiencing traumatic events in mental health settings.[200]

Witness Ms Anna Wilson described a traumatic experience of her son, Harold, being restrained in a mental health setting:

> **People are often restrained on trolleys in emergency departments, drugged up with diazepam and other sedatives and then sent home. On one occasion Harold was restrained to a trolley in the emergency department for hours yelling and screaming, which was horrendous and traumatic for Harold and awful for the people around.**[201]

Evidence suggests that 'coercive, compulsory and restrictive practices can retraumatise people and prevent healing from trauma'.[202] These processes conflict with principles of trauma-informed care, such as developing trust and safety[203] and can adversely impact recovery from trauma.[204] Some consumers who experience coercive practices may have an aggressive response or disengage from treatment.[205]

Research suggests that for many consumers with experience of trauma, mental health practices can remind consumers of previous trauma experiences[206] and cause consumers to 'relive' the traumatic experience; this is explored further in Chapter 31: *Reducing seclusion and restraint*. Despite this, people who have been exposed to childhood trauma, and some other forms of trauma, are likely to spend longer in seclusion, have longer and more frequent admissions, and receive more medication.[207]

Many consumers who gave evidence to the Commission via Victoria Legal Aid's *Your Story, Your Say* submission recounted negative experiences of 'power and control' (such as clinician and client dynamics) within the mental health system.[208] Lived experience workers and peer supports can be an effective complementary support option but remain limited in the mental health system.[209]

There is an inconsistent understanding of how trauma exposure can result in a broad range of mental health outcomes (such as those described in Figure 15.2).[210] In particular, some responses to trauma, such as aggression[211] or substance addiction,[212] have been incorrectly regarded as behavioural issues, rather than mental health outcomes or mental illnesses arising from trauma.[213] As a consequence, many of these consumers miss out on mental health support for their trauma.[214] In addition, a lack of systemic training and support perpetuates 'confusion' on how to respond to people with anger or aggression and can have the unintended effect of exacerbating trauma.[215]

Evidence indicates that consumers exhibiting aggressive behaviours arising from trauma often end up being 'dealt with solely by the justice system', rather than receiving therapeutic support in the mental health system.[216] Witness Mr Grant Todd, described his experience of being found not guilty of an offence because of mental impairment. This resulted in Mr Todd being admitted to Thomas Embling Hospital, where he received support for anger management:

> I had a lot of therapy at Thomas Embling, including group therapy. I had one on one psychology sessions, and while at the acute unit I took anger management sessions. I also did a drug and alcohol group. Some people have to complete the 'offending group' therapy session but I missed this session. Instead, my psychologist asked me to go away and make a pie chart of everything that contributed to my offence. For me, it was a relationship breakdown, losing contact with my family, self-medicating with drugs, my mental illness and my mood disorder. I did all the percentages on the chart and took it back to my psychologist and his feedback was that I didn't need the group therapy because I knew exactly why I had offended. I took something away from that – when I am well, I have a lot of insight.[217]

The diversity of trauma sources and causes, in addition to the highly unique and individual manifestations of stress, make the process of identifying trauma and enabling recovery highly nuanced and complex. However, failure to adequately recognise or screen for trauma, can lead to misdiagnosis and inappropriate treatment planning.[218]

15.6.7 Failure to recognise the impacts of trauma on families, carers and supporters

Evidence indicates the many deficiencies of the mental health system in supporting the families, carers and supporters of people who have experienced trauma.[219] Witness Ms Melanie Hill described supporting her daughter, Natasha, who experienced trauma at an early age:

> To me, the system does not know how to treat people and families affected by trauma. I feel like as a mother and a carer I am only seen by acute mental health services in complete crisis and then I am assessed as being crisis-driven or overly emotional. I have felt judged and misunderstood and throughout the process developed my own paranoia from my experiences in the mental health system. I have had to tell our story so many times that in the end there is little effect or emotion and each new person treats you differently. I have such a distrust for the system.[220]

Witnessing compulsory treatment and restrictive practices on loved ones can be traumatising.[221] Evidence indicates that the failure to receive mental health support for trauma can also lead to a cycle of intergenerational trauma.[222]

The Commission has been told, however, that a trauma-informed mental health and wellbeing system will support the workforce's understanding of 'what trauma does to people', and how they can be treated in order to mitigate the 'dreadful experiences', both for the consumer and families, carers and supporters.[223] As this chapter has identified, enquiring about a trauma history is crucial[224] and can be instrumental to long-term recovery.[225] This approach will benefit not only consumers impacted by trauma, but families, carers and supporters as well.

Witness Ms Denna Healy shared her experience of learning about her father's trauma history following his suicide attempt. Learning about his trauma history helped her to see the 'strength in him':[226]

> We found out in 2014 that my dad had experienced childhood trauma. That played an integral part in my healing because for the whole year since he tried to take his life, I kept questioning myself – asking myself what ifs, what if I had picked up on his behaviour, what if I'd known? The moment I found out about his trauma, it felt like I could give a part of that back to him and be like this isn't mine to carry around anymore.[227]

The critical support role played by families, carers and supporters in wellbeing and recovery is imperative to the future mental health and wellbeing system and is discussed in Chapter 19: *Valuing and supporting families, carers and supporters*. In circumstances where supportive relationships are not readily available, or are strained, the system must be equipped to facilitate access to community supports.[228]

15.7 A new response to trauma

Evidence before the Commission paints a clear picture of the pervasive and often life-long impacts of trauma on mental health and the critical need for the mental health system to provide early support.[229] The Commission agrees that if trauma and its impacts were 'better understood, mental illness would be better understood, managed and treated'.[230]

In considering the breadth of evidence before it, the Commission has determined the current mental health system's response to consumers affected by trauma is inconsistent and largely inadequate. This has not been caused by an unwillingness of the mental health workforce or individual services to respond to trauma; rather, it stems from the mental health system's predominantly biomedical focus,[231] and from the absence of a system-level requirement to screen for trauma.[232] This has meant the mental health system at large has been ill-equipped and under-supported to meet the needs of consumers affected by trauma. It has also resulted in a mental health system that provides inconsistent access and support for these consumers.[233]

The Commission supports the view that trauma 'needs to be removed from its silo and integrated with the complexities of other mental health disorders and persistent social factors.'[234] By embedding a trauma-informed approach across the entire mental health and wellbeing system, consumers will benefit from a system that recognises that trauma is a determinant of mental illness;[235] facilitates early support; reduces the risk of retraumatisation; and matches consumers with supports to aid recovery within and outside of the mental health and wellbeing system.[236] A system that is 'soothing and stabilising' upon first contact will increase the likelihood of consumers engaging with services and taking up further support.[237] Evidence in this chapter emphasises the need for a mental health and wellbeing system that can better meet the needs of consumers whose mental health has been affected by trauma.

The Commission recommends that by the end of 2022, a statewide service is established for consumers affected by trauma. The role and organisation of statewide services in the future mental health and wellbeing system is more broadly described in Chapter 5: *A responsive and integrated system*. Chapter 5 describes the benefits of statewide services for consumers and the mental health and wellbeing workforce, and defines statewide services as delivering:

- a workforce with a high level of expertise and knowledge
- a dedicated research focus
- a focus on providing treatment, care and support to a proportionately small number of people, often with higher levels of needs.

Given the extent and variation of trauma experienced by people living in Victoria, and given the harm that trauma can inflict on mental health and wellbeing, the Statewide Trauma Service will be required to support the mental health needs of a potentially much greater number of people than might be expected in other statewide services.

As such, the new Statewide Trauma Service will support the training and professional development of up to three trauma practitioners who will be embedded in each Area Mental Health and Wellbeing Service. The Commission asserts that the Statewide Trauma Service must be part of the Collaborative Centre for Mental Health and Wellbeing. Locating the Statewide Trauma Service within the Collaborative Centre for Mental Health and Wellbeing will facilitate system-wide opportunities for trauma education and training and support the upskilling and professional development of trauma practitioners—and the broader mental health and wellbeing workforce—now and into the future. This is described further in Chapter 33: *A sustainable workforce for the future*.

The Statewide Trauma Service will be responsible for driving exemplary, trauma-informed practice across the mental health and wellbeing system.[238] As an immediate priority, the Statewide Trauma Service will develop education and training programs to increase the mental health system's capability to recognise and respond to trauma. It will draw together trauma expertise from across the state to identify gaps in knowledge and undertake translational research. The Statewide Trauma Service will also work alongside existing trauma specialist services, registered training organisations and people with lived experience of trauma to establish a training and development program for the accreditation and continuing professional development of specialist trauma practitioners.

These reforms mean that in the future mental health and wellbeing system, consumers impacted by trauma—and, where appropriate, their families, carers and supporters—will have access to local, holistic and therapeutic mental health supports. Primary healthcare providers, such as GPs, will be provided with clear pathways to facilitate further care for consumers experiencing chronic or worsening mental health as a result of trauma. Furthermore, consumers will be served in safe, trauma-informed settings.

Consumers will be supported by specialist trauma practitioners through the development of a referral policy which will endeavour to support all consumers impacted by trauma, regardless of:

- age and personal background
- mental health diagnosis (meaning that people experiencing subsyndromal conditions will be eligible for statewide trauma services)
- chronic, worsening or episodic mental health
- the type or source of trauma experienced
- whether or not the trauma was recent
- whether or not the trauma occurred in Victoria (for example, Victorians who were exposed to trauma overseas, or refugees and asylum seekers who have settled in Victoria and have pre-arrival exposure to trauma will be eligible for statewide trauma services).

Consumers will benefit from early mental health support for their trauma. This includes an awareness of the impacts that adverse life events occurring at young, developmental ages can have. Where appropriate, broader engagement with the consumer's family, carers and supporters will be offered, providing the opportunity for them to take part in recovery planning through family-inclusive practices. These practices will seek to assist consumers, families, carers and supporters to regain a sense of wellbeing and connection and support the maintenance of key social support networks for the consumer.

These changes will provide consumers with more equitable, accessible and streamlined supports that offer choice and agency in their recovery.

15.7.1 A system that provides local, therapeutic-levels of support for consumers affected by trauma

In Victoria's reformed mental health and wellbeing system, consumers who require support for their mental health following exposure to trauma will have access to specialist support in their local area. Trauma practitioners will comprise a multidisciplinary workforce (with a range of base qualifications) developed through an accredited training program overseen by the Statewide Trauma Service.

Working alongside peer support workers, trauma practitioners will assist consumers with the development of a recovery plan, with a range of support available to the consumer.[239]

Specialist trauma practitioners will consider how the experience of trauma interacts with 'other complex problems in a person's life'[240] and will be enabled to provide therapeutic and holistic care.

The responsibilities that trauma practitioners have will include, but not be limited to:

- undertaking primary consultation
- undertaking mental health assessments
- developing and/or reviewing treatment and recovery plans
- providing individual and team supervision
- participating in consultation liaison and other clinical meetings
- working closely with the Area Mental Health and Wellbeing Service clinical manager, consultant psychiatrists, psychiatric registrars and other clinical staff, to ensure procedural requirements are closely followed
- working in partnership with practitioners across the different levels of the mental health and wellbeing system, to form multi-practitioner care teams that will provide shared clinical care
- maintaining appropriate records and providing reports, as appropriate and required by the Statewide Trauma Service
- delivering evidence-based individual and group therapies, in addition to consumers' usual case management supports
- establishing and maintaining referral pathways to enable consumers with mental illness to access other necessary supports (such as general health, housing, employment, education/training and family services)
- evaluating clinical practices and systems against research evidence, and identifying areas for improvement
- identifying opportunities for further research activities, preferably in collaboration with the Statewide Trauma Service via the trauma community of practice.[241]

15.7.2 Developing and embedding trauma-informed practice across the mental health and wellbeing system

Adopting a trauma-informed approach requires training the broader mental health and wellbeing workforce to recognise and understand the mental health impacts of trauma, and to be sympathetic towards those who have experienced trauma.[242] In the future mental health and wellbeing system, the workforce will be supported to be trauma-informed through education and training that is underpinned by evidence and research.

Trauma practitioners will have the knowledge and skills to recognise and respond to the diverse range of mental health effects of trauma (such as those described previously in Figure 15.2 and Table 15.1), including behavioural adaptations to trauma.[243] They will assist consumers, families, carers and supporters to seek support from a range of service providers[244] and, where required, facilitate access to trauma specialist services.[245]

Trauma practitioners will work to promote continuous improvement in trauma-informed practice across the Area Mental Health and Wellbeing Services they are embedded in, and Local Mental Health and Wellbeing Services they are deployed to. To achieve this, the Commission proposes that trauma practitioners attend (virtually or face-to-face) the Statewide Trauma Service for one day a week, or for 20 per cent of their time where they will have access to:

- a structured program, including orientation, training, assistance in the development of management plans for consumers, clinical supervision and secondary consultation (these supports will be in addition to the usual quality and safety mechanisms that are part of clinical practice and governance arrangements)
- proactive support for referrals from the local service to the Statewide Trauma Service, and intensive treatment for the most complex trauma cases.[246]

To ensure continuous improvement, the Statewide Trauma Service will bring together trauma practitioners and trauma experts from across the state to contribute to a statewide community of practice. The community of practice will provide an opportunity for collaborative learning (sharing lessons and insights), reflective practice and building trauma-informed capability across the system.[247] Regular supervision, multidisciplinary case management and supervisors 'talking through' complex cases will be encouraged, offering additional practice support for consumers presenting at a range of mental health settings.[248] This will support trauma practitioners to develop and sustain a trauma-informed approach to their work.[249]

15.7.3 Access to peer support workers and online support networks

Social connection and peer support are key protective factors for mental illness. Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect* describes the Commission's recommended approach to supporting the social connectedness of all Victorians, and to supporting consumer engagement in local community activities. The Commission also considers that access to lived experience workers, including peer support workers, can support recovery and healing for consumers affected by trauma. It is the

Commission's position that opportunities for moderated and facilitated online peer support are worthy of further exploration.[250]

In the future mental health and wellbeing system, consumers will have access to a range of peer support workers via Area Mental Health and Wellbeing Services and Local Mental Health and Wellbeing Services, as described in Chapter 33: *A sustainable workforce for the future*. Lived experience workers will support consumers and advocate for a range of consumer needs, including the needs of those recovering from trauma.[251] They will also provide consumers with increased choice over the supports they receive.

Opportunities for consumers to join or access moderated online support forums will also be facilitated by the Statewide Trauma Service.[252] Run by consumers and peer support workers through the Statewide Trauma Service, online trauma support networks will be grounded in peer work and will provide consumers with a range of support options and advice, including:

- access to social support and networks
- advice on treatment decision making[253]
- access to support they can receive at home[254]
- navigation of mental health supports and self-help.[255]

Peer support workers will also be supported by training and education delivered through the Statewide Trauma Service.

15.7.4 A system that is supported and equipped to deliver exemplary mental health care for consumers affected by trauma

The Commission's recommendation for a Statewide Trauma Service will position trauma as a core focus of Victoria's mental health and wellbeing system. Embedded in the Victorian Collaborative Centre for Mental Health and Wellbeing, the Statewide Trauma Service will support the delivery of mental health treatment, care and support for consumers living with complex conditions, who have not benefitted from traditional service models.[256]

The provider of the Statewide Trauma Service will be determined by an expression-of-interest process and will be implemented by the end of 2022. In considering the preferred provider, the Victorian Government must ensure that the applicant works to establish genuine, collaborative partnerships with:

- a diversity of consumers, peer and lived experience workers, trauma clinicians, trauma experts and academics
- third-party and industry-funded recovery services
- trauma specialist services.

As priority actions and outputs, the Statewide Trauma Service will:

- bring together a network of services from across Victoria that work with consumers affected by trauma to identify knowledge gaps and opportunities for translational research
- develop and deliver, as a component of broader mental health system workforce reforms, a plan to increase understanding of trauma, build capability to respond to trauma, and promote best practice across the mental health system
- develop and deliver a trauma training program to accredit trauma practitioners across the state
- work in partnership with peer support workers and consumer advisers to codesign strategies, policies and targets to embed trauma-informed practice across the mental health system.

Once established, the Statewide Trauma Service will build and maintain close relationships with Area Mental Health and Wellbeing Services. The Statewide Trauma Service will work in partnership with trauma practitioners to develop local models to improve the ability of the broader clinical workforce to identify, assess and treat consumers affected by trauma. In addition to supporting individual trauma practitioners, the Statewide Trauma Service will coordinate trauma education, training and collaboration across trauma practice.

This will include:

- contributing to an evaluation framework
- collecting data and information, and reporting to the department about the approach undertaken by the Statewide Trauma Service and trauma practitioners
- developing written or multimedia resources for all Victorian mental health services, including:
  - guidelines for the referral of consumers to the Statewide Trauma Service
  - principles and standards of care (consistent with the *National Mental Health Medical Research Council's Guidelines for Best Practice*) for the treatment and management of consumers who have experienced trauma
  - a statewide risk assessment and risk management protocol for consumers who have experienced trauma
  - core competencies that all mental health clinicians need to have, to better support consumers who have experienced trauma.[257]

The Statewide Trauma Service will contribute to the service capability framework (described in Chapter 5: *A responsive and integrated system*) to inform capability development in trauma and recovery across mental health and wellbeing service providers.

15.7.5 A system that provides a coordinated response

People affected by trauma often require support from multiple service systems. Recognising this, the Statewide Trauma Service will bring together key services working with consumers affected by trauma. This will include a broad range of trauma specialist services (such as sexual violence, refugee and torture services), and will also include organisations such as:

- Forensicare (supporting consumers in the justice system)
- Spectrum (supporting consumers with personality disorders)
- the statewide service for people living with mental illness and substance use or addiction.

This will ensure that critical partnerships and collaborations between the mental health system and trauma specialist services can be maintained in the long-term, complementing and strengthening the work of each service.[258]

15.7.6 A system that is based on a contemporary and consolidated understanding of trauma

The dominance of the biomedical model has constrained the extent to which mental health services have been able to build understanding and knowledge about the delivery of trauma-informed care and practice.[259] To address this, the Statewide Trauma Service will have a key focus on building trauma knowledge and understanding through coordinated, multidisciplinary, translational research into trauma. The intention of the research should be to improve outcomes for consumers who have been impacted by trauma, and to support the mental health workforce to recognise and respond to trauma.

As Professor Alexander McFarlane AO, Professor of Psychiatry in the School of Medicine at the University of Adelaide, explained:

> Very often, both mental health and trauma are not viewed or approached broadly and with an understanding of their role in many and varied presentations and diseases. Research indicates that there is a broad range of risk factors, genetic and biological, for psychiatric disorders, and there are many shared mechanisms that go across the spectrum of disorders. It follows that centralised and co-ordinated research and assembly of learning and knowledge is vital in order that sophisticated understanding can be assembled and imparted.[260]
>
> Peak bodies of this kind can be a resource for the entire system as a central repository for knowledge, learning and research.[261]

The Statewide Trauma Service will work to distribute this knowledge across the mental health and wellbeing system in a manner that keeps pace with the evolving understanding of trauma and mental health.[262] The intention should be to advance research into evidence-based treatments for post-traumatic mental illnesses, and to ensure that the best available evidence is being translated in community mental health settings.[263] Bringing together evidence-based treatments and individual preferences is 'the wave of the future',[264] and will be an important focus of the future mental health and wellbeing system.

15.7.7 A workforce that is equipped to respond to trauma through comprehensive education and training

The Commission heard that both entry-level and advanced trauma education and training is required in the mental health and wellbeing system.[265] This includes increased opportunities to train practitioners in evidence-based trauma treatments. Currently, there is only a 30–40 per cent chance that a consumer in the public mental health system will be supported by someone with training in these therapies.[266]

Drawing on coordinated trauma expertise, the Statewide Trauma Service will develop and deliver training to support the multidisciplinary trauma workforce in Victoria. Importantly, the Statewide Trauma Service will design and deliver an accredited program of training specific to the trauma practitioner roles. The Commission has heard of the efficacy of this model.[267]

Trauma education and training will support the broader mental health and wellbeing workforce to:

- understand trauma and its impacts
- develop skills to work sensitively with individuals affected by trauma
- develop skills and strategies to assist trauma-affected consumers to manage their behaviours/emotions, to problem solve and build social connections and self-care.[268]

Skills-based training is critical to responding to trauma,[269] and complements other core components of mental health care, including family-inclusive practice.[270] This training will support the mental health workforce to feel equipped and supported to ask about trauma, and respond in a way that supports consumers and themselves if trauma is disclosed.[271]

To support this approach, a whole-of-organisation response (such as screening policies and debriefing procedures) should be developed to support staff and consumers to engage about trauma.[272] This includes formal training and staff development opportunities to manage any vicarious experiences of trauma.[273] There will be a 'package' of policies, including training, peer support, and the ability for early intervention in work settings, through appropriate social and support systems.[274]

The Statewide Trauma Service will also recognise the importance of education, training and support for the lived experience support workforce.

15.7.8 A system that fosters and sustains a trauma-informed approach

The Commission has been told there is a 'real challenge' in translating the evidence about trauma and its impacts on mental health into practice.[275] Organisational or system cultures, lack of supervision and support, and confusion or apprehension regarding trauma-informed principles, have been described as key barriers to trauma-informed practice across the mental health system.[276] This situation is compounded by a lack of trauma expertise within the general mental health system,[277] and limited training opportunities to advance understanding of trauma and its impacts in practice.[278]

The Statewide Trauma Service will champion continued development and support for the mental health and wellbeing system to embed a trauma-informed approach. In this context, a trauma-informed approach is considered a system wide reform—developing a workforce skilled to work sensitively with consumers, and to develop strategies that assist consumers in managing their behaviours and emotions, building their social connections and improving their personal care. Importantly, trauma-informed care also involves understanding 'ways to engage with trauma-affected people to minimise the likelihood of worsening the effects of the trauma on that person.'[279]

The Statewide Trauma Service will provide continuous support and oversight of the codesigned trauma-informed practice across the mental health and wellbeing system. It will do this through the development and implementation of a range of methods, consisting of service planning and evaluation; service delivery and program development; and workforce development and training.[280] This will include working with the Collaborative Centre for Mental Health and Wellbeing to develop strategies and frameworks that reduce traumatisation and retraumatisation occurring within the system.

A substantive, whole-of-government response is required to embed and sustain trauma-informed practice.[281] Development and alignment of policies and frameworks, and ongoing education and personal development, will sustain a culture that is aware and responsive to the needs of consumers affected by trauma. Evidence indicates that this approach can be of significant benefit to consumers, families, carers and supporters, as well as the mental health workforce.[282]

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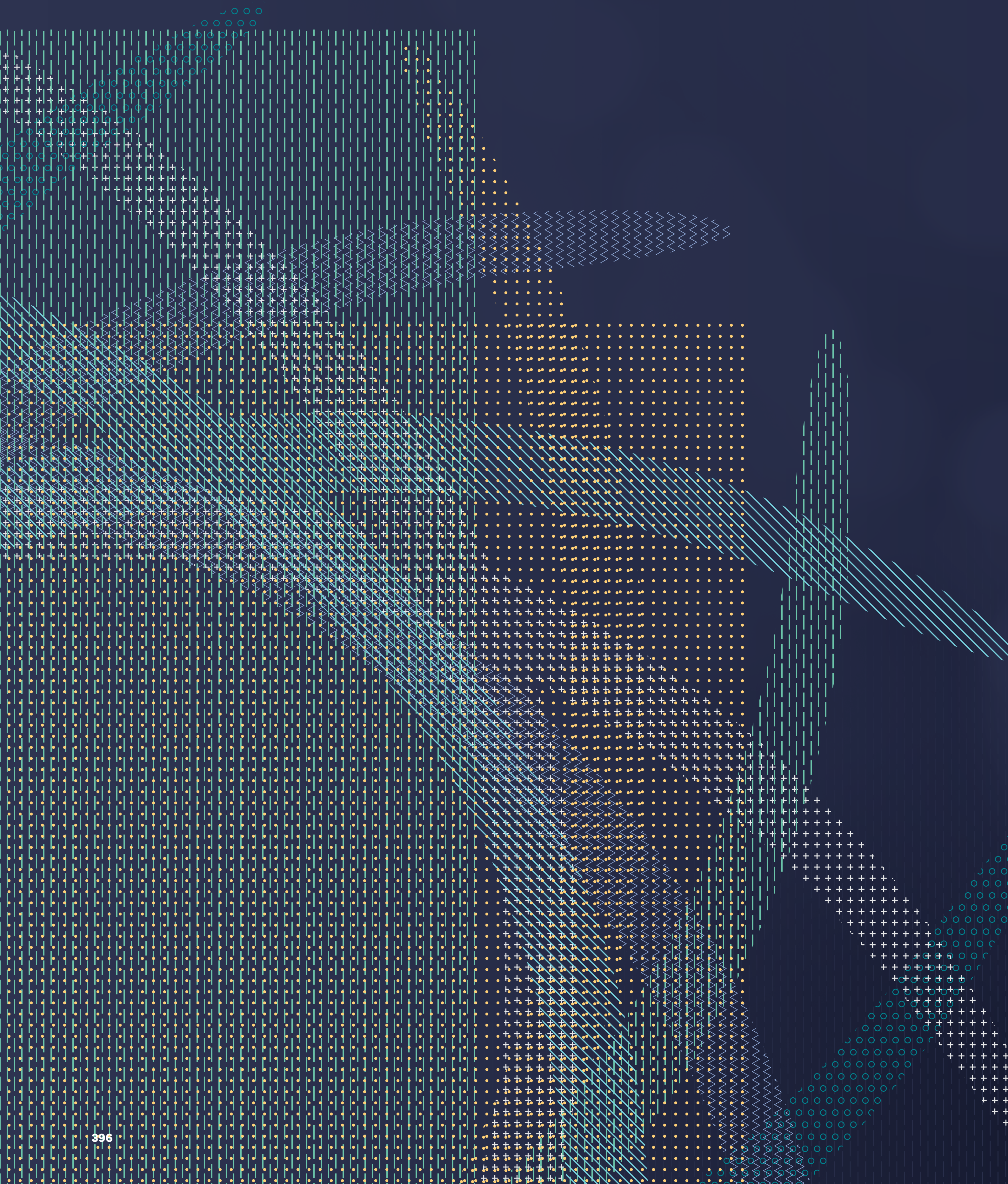


Chapter 16

Supported housing for adults and young people

Recommendation 25:

Supported housing for adults and young people living with mental illness

The Royal Commission recommends that the Victorian Government:

1. recognise people who are living with mental illness as a priority population group as part of Victoria's 10-year strategy for social and affordable housing and ensure that, during the next decade, people living with mental illness are allocated a continuing substantial proportion of social and affordable housing.
2. revise the Victorian Housing Register's Special Housing Needs 'priority access' categories to include people living with mental illness, including people who need intensive ongoing intensive treatment, care and support.
3. ensure that the 2,000 dwellings assigned to Victorians living with mental illness in the Big Housing Build are delivered as supported housing and are prioritised for people living with mental illness who require ongoing intensive treatment, care and support, with Area Mental Health and Wellbeing Services assisting with the selection process.
4. in addition to the 2,000 dwellings, invest in a further 500 new medium-term (up to two years) supported housing places for young people aged between 18 to 25 who are living with mental illness and experiencing unstable housing or homelessness.
5. ensure that the supported housing homes for adults and young people living with mental illness are:

   a. delivered in a range of housing configurations including stand-alone units, self-contained units with shared amenities and various forms of clustered independent units on a single-site property;
   b. appropriately located, provide for the requirements of people living with mental illness and are co-designed by Homes Victoria, representatives appointed by the Mental Health and Wellbeing Division and people with lived experience of mental illness; and
   c. accompanied by an appropriate level of integrated, multidisciplinary and individually tailored mental health and wellbeing treatment, care and support.

6. periodically review the allocation of supported housing homes as part of the statewide and regional planning processes recommended by the Royal Commission (refer to recommendation 47) and audit the outcomes.

16.1 A stable home is essential for a 'contributing life'

A stable home can bring a sense of safety, security and belonging—all of which are fundamental to a person's mental health, wellbeing and ability to lead a contributing life.[1] In accordance with the National Mental Health Commission's *A Contributing Life* framework,[2] the Royal Commission defines a 'contributing life' as one in which a person is able to flourish, not just survive. This reflects every person's right to 'full and effective participation and inclusion in society' enshrined under the *Convention on the Rights of Persons with Disabilities*.[3]

For a person experiencing mental illness, a stable home can be transformative, bringing with it a sense of purpose, hope and opportunity.[4] Having access to a secure house means that a person no longer has to worry about where they will be living in a day, week or month, allowing them to focus their attention on their own mental and physical health, their relationships, community participation and their aspirations for the future. As put to the Commission by one person with lived experience of mental health and housing issues, 'I don't understand how you can have stable mental health if you don't have stable housing'.[5]

The Commission has received evidence on the state of Victoria's housing crisis and the direct impacts it is having on the mental health of Victorians and the operations of Victoria's mental health system.[6] Yet, as the Commission has been appointed to inquire into Victoria's mental health system, the letters patent require it to focus its reform agenda on initiatives that will deliver the best mental health outcomes for people experiencing mental illness and homelessness.[7]

Targeted housing and support services will form a fundamental component of the future mental health system as part of the extended rehabilitation pathway recommended by the Commission. As set out in Chapter 10: *Adult bed-based services and alternatives*, the future system will deliver an extended rehabilitation pathway to support people living with mental illness or psychological distress who require ongoing intensive treatment, care and support to achieve and maintain their greatest level of independence and mental health.

The Commission welcomes the Victorian Government's unprecedented $5.3 billion Big Housing Build to develop more than 12,000 social and affordable housing homes for Victorians by 2024. The Commission particularly welcomes the government's investment in 2,000 homes to support Victorians living with mental illness. This level of investment is nation-leading. It is a critical step in addressing the housing crisis in Victoria and in addressing the mental health, wellbeing and safety of the state's most vulnerable and marginalised groups more broadly.

Beyond the Big Housing Build, resolution of Victoria's housing crisis will require a continuing whole-of-government response that extends well beyond this inquiry. In the context of the Commission's remit, the reforms proposed in this chapter are an initial step to providing a strong foundation for longer-term housing reforms in Victoria. Only continued reform in the long term will achieve full realisation of the internationally recognised human right to adequate housing.[8]

16.1.1 People with lived experience reside in a variety of settings

In its inquiries, the Commission investigated a broad range of housing situations that can influence a person's mental health, as well as the mental health of the people they live with or are supported by, including family members, carers, friends or kinship groups.

People of all ages living with mental illness or psychological distress tend to experience more variation in their housing than the general population.[9] This cohort often cycles through private rental accommodation, social housing, supported accommodation, boarding houses, caravans, living with family and friends and various forms of homelessness.[10]

The fluctuating nature of mental illness—and the associated challenges it can bring to a person's financial, economic or social circumstances—is a key reason for this cohort's increased susceptibility to housing instability. This is often characterised by a person being forced to move and being uncertain about where they will live in the coming days, weeks or months.[11]

People living with mental illness or psychological distress also tend to rely more heavily on social housing than the general population.[12] Social housing covers two distinct forms of subsidised rental housing: public housing, which is owned and operated by the Victorian Government and community housing, which is owned and operated by community housing providers.[13]

According to the 2016 Census, it is estimated that more than 24,000 Victorians are experiencing homelessness on any one night.[14] In 2018–19, 112,900 Victorians sought assistance from specialist homelessness services, which are designed to assist people currently experiencing, or at risk of experiencing, homelessness.[15] In the same year, 11 per cent (or approximately 12,800 people) who sought specialist homelessness support were identified as active consumers in Victoria's public mental health system.[16]

According to Dr Sarah Pollock, Executive Director of Research and Advocacy at Mind Australia, there are up to 30,000 Victorians living with 'severe mental illness' who are currently residing in unsuitable, unsustainable or unsafe living arrangements, for themselves and for those they live with.[17] Dr Pollock estimates that approximately 20,000 Victorians in this cohort are residing in inadequate forms of supported accommodation, or with family members and would live independently if they could access adequate housing and support. A further 6,000 to 11,000 people in this cohort are homeless.[18]

Adopting the Australian Bureau of Statistics' statistical definition of homelessness, the Commission considers a person to be homeless if they have no choice but to live in an inadequate dwelling that has limited to no security of tenure and prohibits control over privacy, personal living space and social relations.[19] This covers a continuum of poor housing arrangements, from rough sleeping in a park through to overcrowded long-stay boarding houses.[20]

The Commission also recognises that Aboriginal and Torres Strait Islander people have a broader understanding of what constitutes homelessness—extending beyond inadequate housing to a 'state of disconnection from one's homeland, separation from family or kinship networks, or not being familiar with one's heritage'.[21]

The Commission notes significant limitations in the current evidence base for the prevalence and experiences of homelessness and housing issues in Victoria.[22] The Commission has observed a reliance on point-in-time Census data that occurs every five years, to understand the prevalence of homelessness in Victoria, leading to a lack of critical insights into the duration, population trends or causes of housing issues in Victoria.[23] It is also clear that a person's housing status is not routinely collected by health services.[24]

Lack of high-quality data has limited the Victorian Government's ability to deliver targeted and meaningful housing and support interventions to people with mental illness.[25] The rectification of this issue through improved data collection, regulation and oversight should be a fundamental component of the Victorian Government's longer-term housing reform agenda.

16.1.2 Mental health affects housing and housing affects mental health

The relationship between mental health and housing is complex and bi-directional (two-way), in which the experience of one can increase a person's vulnerability to experiencing the other.[26]

While mental illness does not guarantee a person's trajectory to homelessness, it does increase a person's likelihood of experiencing housing instability or homelessness, relative to the general population.[27] Mental illness is often associated with increased access barriers to employment, experiences of family violence, social isolation and loss of independent living skills; all of which contribute to an increased risk of housing breakdown.[28]

For instance, there is evidence suggesting that fluctuations in a person's mental illness can result in transitions in and out of unemployment, limiting a person's financial resources and ability to maintain housing.[29]

Associate Professor Dan Siskind, Clinical Academic Psychiatrist at Princess Alexandra Hospital in Queensland, speaking in his personal capacity, also points to various cognitive issues that can accompany mental illness as another reason for the heightened risk of homelessness or housing instability among those with mental health issues:

> To understand this link [between mental health and housing], we need to recognise that, for a person to find and maintain housing, they must complete many complex tasks. These tasks include identifying a suitable [house]; securing sufficient income to pay rent and utilities [and] financial management skills … These tasks are in addition to the daily tasks required to maintain a clean house and ensure self-care … Because of the nature and impacts of their illness, people with severe and persistent mental illness often have a number of impairments [including auditory hallucinations, cognitive decline and loss of motivation] which limit their ability to perform the tasks required to find and maintain stable and secure housing.[30]

The experience of mental illness or psychological distress can also limit a person's ability to maintain interpersonal relationships as it 'can cause individuals to withdraw from or overtax their support networks, thereby eroding the informal resources available to them in times of crisis.'[31] As has been stated by the Australian Housing and Urban Research Institute, for people living with mental illness '[t]heir lack of financial and human resources makes them particularly vulnerable to living in situations of risk [such as] abuse and vulnerability to drugs and alcohol.'[32]

Likewise, the experience of housing instability or homelessness increases a person's likelihood of experiencing substance use and addiction issues, loss of formal and informal support networks and trauma. All of these can also trigger or exacerbate a person's mental health issues and contribute to more complex support needs.[33]

Limited financial resources, a lack of a fixed address or permanent contact details and comorbid substance use and addiction are just some of the identified barriers to mental health treatment, care and support, for people experiencing homelessness or unstable housing.[34] There is also evidence that some consumers are being excluded from mental health treatment, care and support on the basis of co-occurring substance use and addiction issues.[35] This is explored further in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*.

As summarised by Professor Karen Fisher, Professor at the Social Policy Research Centre, University of New South Wales:

> **The link between mental health and housing and homelessness is multi-directional—it is not just that housing affects mental health; mental health also affects housing. If someone has unstable housing then it is likely to extenuate the incidence and impact of pressures on their mental health by either causing mental ill health or causing other related conditions that affect mental health such as poverty, violence and disability. In the other direction, mental ill health without adequate support risks housing instability. The capacity of someone to maintain their housing, employment and social relations is affected by their mental health.**[36]

Accordingly, without adequate and timely intervention, people living with mental illness or psychological distress, as well as housing challenges, are highly susceptible to a lifelong trajectory of cycling in and out of service systems, different living arrangements and poor mental health.[37] Certain population groups are also more susceptible to co-existing mental health and housing issues requiring high-intensity care and support, including Aboriginal and Torres Strait Islander people,[38] the LGBTIQ+ population,[39] older adults aged 55 or over[40] and young people leaving out-of-home care.[41]

16.2 Victoria's housing crisis affects mental health

Victoria's housing market is becoming increasingly inaccessible as housing prices rise and demand continues to dramatically outweigh supply.[42] Over the past 20 years, rates of home ownership have significantly declined,[43] more people are renting,[44] and fewer people are able to secure access to social housing.[45]

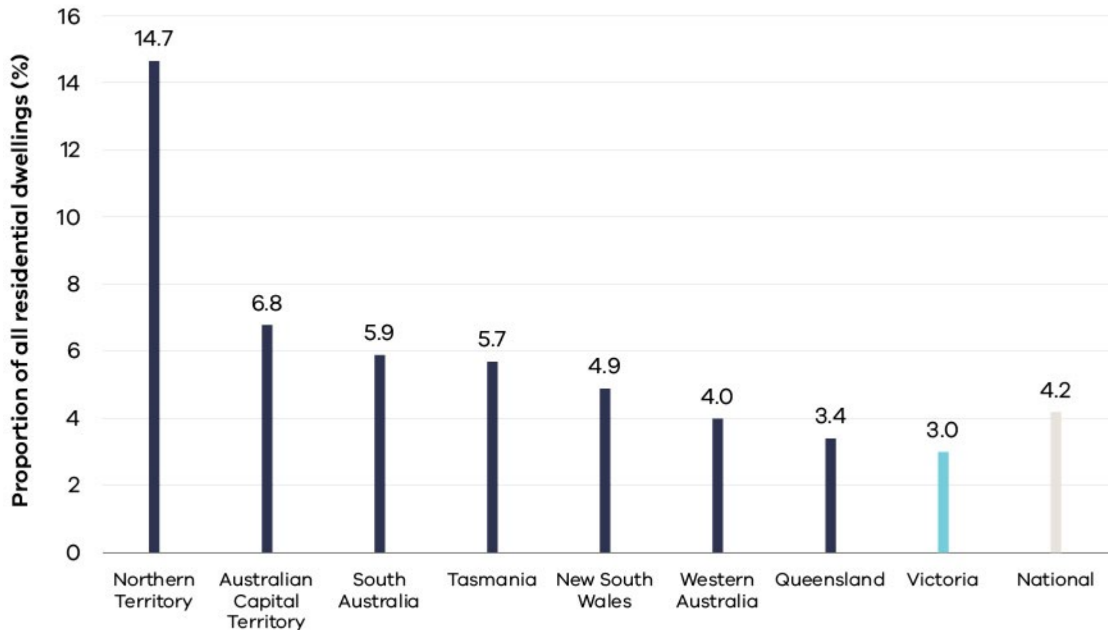
The COVID-19 pandemic has shone a spotlight on the scale of Victoria's housing and homelessness crisis, including the critical shortage of social housing dwellings. Confronted by increased challenges to health and wellbeing, the Victorian Government had to respond to the housing and support needs of Victoria's homeless population.[46]

In the absence of sufficient social housing stock, between March and June 2020 the Victorian Government allocated approximately $25 million to the provision of temporary housing in repurposed aged-care facilities and hotels. This enabled approximately 4,500 people to access safe accommodation, largely eliminating the presence of rough sleeping in Melbourne's central business district during this period.[47]

In its interim report published on 4 August 2020, the Parliamentary Inquiry into the Victorian Government's Response to the COVID-19 Pandemic highlighted that specialist homelessness services were experiencing increased demand as a consequence of the COVID-19 restrictions.[48] The report calls for further government expenditure on social housing 'in order to both provide housing support to vulnerable Victorians and to stimulate the economy in the post-pandemic period.'[49]

The inadequacy of Victoria's social housing stock is widely documented and was a cause for concern even before the COVID-19 pandemic.[50] As shown in Figure 16.1, compared with all other Australian states and territories, Victoria has the lowest percentage of social housing stock as a proportion of all occupied dwellings. Furthermore, in the financial year 2018–19, Victoria spent approximately half of the national average on social housing per person: $92 per person, compared to $159 per person.[51]

Figure 16.1: Proportion of social housing dwellings of all residential dwellings, states and territories, 30 June 2019



Source: Commission analysis of Australian Institute of Health and Welfare, *Housing assistance in Australia 2020: Social housing dwellings*. Table Dwellings.2; Australian Bureau of Statistics, Residential Dwellings: Values, Mean Price and Number by states and territories <stat.data.abs.gov.au/Index.aspx?DataSetCode=RES_DWEL_ST> [Accessed 26 October 2020].

Social housing is intended to operate as a safety net for low-income and marginalised households, but due to chronic underinvestment, it has become so highly rationed that only the most disadvantaged people are granted access and people with mental illness are considered just one of many cohorts in desperate need.[52]

The Family Violence Housing Assistance Implementation Taskforce has estimated that an additional 30,000 social housing dwellings are required in Victoria by 2036, based on projected population growth over the next 20 years.[53] This doubles to 60,000 new dwellings if the Victorian Government is to provide affordable housing to low-income households currently experiencing 'rental stress', meaning that these households are spending more than 30 per cent of their income on housing.[54]

As noted earlier, the Commission welcomes the Victorian Government's $5.3 billion Big Housing Build to develop more than 12,000 social and affordable housing homes for Victorians by 2024, including 2,000 for people living with mental illness. The Commission recommends a continuation of this form and scale of expenditure beyond 2024 to mitigate the consequences of the chronic underinvestment that has occurred in Victoria to date.[55]

There is evidence to suggest that targeted and integrated housing and support initiatives for people with mental illness deliver significant returns on investment.[56]

For instance, in KPMG's recent research report, *Investing to Save*, it was reported that for every $1 spent on integrated housing and support for young people with mental illness, $3 is created in the short term and $6.70 is created in the long term.[57] These savings are attributable to lower healthcare costs, reduced engagement in the criminal justice system and higher rates of employment. Consequently, if the government were to spend $0.5 billion on integrated housing and support solutions for young people with mental illness, this would generate approximately $1.5 billion in savings in the short term and $4.8 billion in the longer term.[58]

16.2.1 The negative impacts of inadequate housing on consumers' mental health

Unresolved housing issues are affecting the operations and efficacy of Victoria's mental health system, giving rise to critical challenges for consumers, families, carers and supporters and mental health services and staff.

Given the correlation between mental illness, housing instability and homelessness, it is not surprising that people experiencing homelessness are exhibiting higher rates of emergency department presentations for mental health–related reasons than those with stable housing. In 2018–19, specialist homelessness service clients accounted for 21 per cent of all mental health-related emergency department presentations in Victoria.[59] Over the past five years, people with an unknown or no fixed address who may be experiencing homelessness have also exhibited higher rates of acute inpatient readmissions for mental health-related reasons within 28 days of discharge—averaging 18.3 per cent of all readmissions, compared with 14.8 per cent for those who were not homeless.[60]

The Commission has heard from consumers, families, carers, supporters and service providers that an unacceptably high number of Victorians are being discharged from hospital for mental health–related reasons to various forms of inadequate housing and homelessness. From the perspective of one consumer, 'it seems like homelessness is an acceptable part of the system'.[61]

In the absence of adequate discharge options, mental health practitioners are often pressured to select one of three suboptimal care decisions when supporting someone who is homeless—discharge them to homelessness;[62] discharge them to housing that is unsafe or unsuitable for themselves or for those they live with;[63] or refuse their discharge and subject them to an extended stay in an acute inpatient setting.[64]

The Victorian Council of Social Service advised the Commission that:

> Far too many people are released from institutions into homelessness. Over 500 people each year are discharged from acute mental health care into rooming houses, motels, rough sleeping or other forms of homelessness.[65]

In its submission to the Commission, NorthWestern Mental Health reported that one in three of its consumers are leaving acute inpatient settings to inadequate living arrangements:

> Around one third of consumers discharged from [NorthWestern Mental Health] inpatient units are currently being discharged to unsafe housing or homelessness … There is a lack of affordable, safe housing options in the community and a lack of crisis accommodation which is suitable for those with a serious mental illness.[66]

When a consumer is discharged to inadequate housing or homelessness, the mental health treatment, care and support received is compromised, often launching them back into a cycle of housing uncertainty and deteriorating mental health.[67] Family members, carers and supporters are often left to fill this service gap, leaving many with no choice but to take in their loved one to prevent an experience of rough sleeping, even when it is unsafe, unsuitable or unsustainable for all involved.[68]

For some people living with mental illness or psychological distress, the lack of suitable accommodation options means they are unable to be discharged and are subject to clinically unnecessary extended stays in acute inpatient settings, which can be costly to both the individual's recovery and the mental health system more broadly.[69] As summarised by the Office of the Public Advocate in its submission to the Royal Commission, 'mental health services are increasingly being treated as accommodation for people with challenging presentations.'[70]

Barwon Health reported:

> **In the middle of June 2019, 60% of consumers admitted to our acute psychiatric unit and subacute units were homeless or had unstable housing. This is problematic for these individuals, impairing their ability to safely discharge into community care and prolonging inpatient length of stay. This also impacts other consumers by limiting availability of inpatient resources due to there being less overall inpatient capacity.**[71]

There is some evidence before the Commission that people who are experiencing homelessness are experiencing access barriers when trying to obtain appropriate mental health treatment, care and support.[72] This is of great concern and must be addressed.

16.2.2 Supported residential services are being relied on to fill the service gap

The lack of adequate housing and support options for people with mental illness is also leading to an increased reliance on privately operated supported residential services to accommodate this cohort at the point of discharge, despite these services neither being adequately resourced nor intended to provide this form of support.[73] Supported residential services are 'privately operated residences that provide accommodation and support [services] for individuals who need help with everyday activities'.[74] These services are regulated by the Victorian Government.[75]

There are 127 supported residential services operating in Victoria. Together, they accommodate more than 3,000 residents, many of whom are living with mental illness and other forms of disability. Each service tends to accommodate between 20 to 50 residents, with some housing up to 80 people.[76] In contrast to rooming houses, supported residential services are not just accommodation services.[77] They are intended to provide accommodation and support to people who require assistance with daily living. Yet there is evidence to suggest that this is not always the case.[78]

Quality and safety concerns about the current operations of these services have been raised with the Commission, particularly given the high rates of mental illness among their residents.[79] In a census completed by the former Department of Health and Human Services in 2018, 'mental illness and psychiatric disability' was identified as the most common form of disability among the 3,142 people living in supported residential services, at a rate of 47 per cent.[80] The most common referral sources were found to be hospitals (64 per cent) and mental health services (52 per cent).[81]

According to the Office of the Public Advocate:

> the [supported residential services] sector is often asked to fill the gap left in the absence of step-up/step-down community-based accommodation for people with mental illness.[82]

Previous inquiries have also raised concerns regarding the quality and safety of these services. For example, the parliamentary inquiry into supported accommodation for Victorians with a disability and/or mental illness in 2010 noted concerns with the suitability of supported residential services for people with mental illness,[83] recommending:

> [t]hat through the review of the supported residential service (SRS) regulations, the Victorian Government improves the SRS industry's capacity to respond to people with a disability and/or mental illness ...[84]

The Office of the Public Advocate's Community Visitors Program, a quality and safety oversight mechanism for supported residential services under the Minister for Health,[85] continues to find evidence of substandard care and living arrangements for residents in this form of accommodation.[86] According to community visitors, staff have limited capacity to provide the necessary supports to residents living with mental illness 'due to them having little or no training' in this area.[87]

In 2018–19, community visitors reported 623 issues of concern, of which 161 related to abuse—including cases of sexual assault, excessive drug misuse, incidents of financial abuse, physical violence and continuous bedbug infestations.[88] In a recent article published by researchers Liz Dearn and Professor Lisa Brophy, comparisons were made between supported residential services and old psychiatric institutions:

> in the 1990s, [supported residential services] morphed to accommodate the large numbers of people with mental illness leaving institutional care who had nowhere else to go ... While Victoria has taken some pride in the closure of large institutions, [supported residential services] endure as small to medium institutions ... As a type of 'closed environment' ... [r]esidents experience a high degree of isolation from the rest of the community and, for many, all aspects of life are lived in this one place.[89]

Acknowledging reports that '[supported residential service] proprietors are generally caring, committed and hardworking',[90] the Commission calls for the Victorian Government to review and reform the operations of these services, with particular focus to be placed on the support needs of residents with mental illness.

16.3 Prioritising mental health in Victoria's long-term housing reform agenda

The provision of stable housing is a core and indispensable element of a comprehensive mental health and wellbeing system. An effective housing and homelessness system, leading to stable housing, goes hand in hand with access to high-quality mental health treatment, care and support.

People living with mental illness or psychological distress must be recognised as a priority population group, as part of Victoria's 10-year strategy for social and affordable housing.[91] This includes young people, adults and older adults. This is particularly critical in light of the COVID-19 pandemic and the anticipated long-term effects of the associated lockdown restrictions on people's mental health, employment opportunities and access to stable housing.[92]

While the 2,000 new dwellings assigned to people with mental illness in the Big Housing Build is expected to have a sizeable and meaningful impact for this cohort and the mental health system more broadly, further investment will be essential.[93] As outlined in section 16.1, it is estimated that between 6,000 and 11,000 Victorians who are living with 'severe mental health issues' are homeless, and a further 20,000 are living in non-preferred housing arrangements for themselves and/or for those they live with.[94]

The Commission recommends that the Victorian Government ensure, throughout the next decade, a continuing substantial proportion of social and affordable housing is allocated to adults who are living with mental illness. It also recommends that the outcomes should be audited, and, in addition, there should be periodic reviews of the unmet need for such housing as part of statewide and regional planning processes recommended by the Commission.

16.3.1 Removing access barriers to social housing

The Commission is of the view that insufficient priority is currently being given to people living with mental illness or psychological distress who are on the waiting list for social housing in Victoria. As previously noted, social housing covers two distinct forms of subsidised rental housing: public housing, which is owned and operated by the Victorian Government and community housing, which is owned and operated by community housing providers.[95] Social housing is for people who cannot obtain access to suitable housing in the private rental market.

Social housing has become increasingly rationed in Victoria following years of underinvestment and population growth.[96] In 2018–19, approximately 111,500 people were on the Victorian Housing Register, which operates as a combined waiting list for both public and community housing, but only 11,000 people were offered housing.[97] Approximately 6 per cent (6,940) of these 111,500 people were also engaged in Victoria's mental health system. Just 729 of them were able to secure housing, as illustrated in Figure 16.2.[98]

Figure 16.2: Mental health consumers and the Victorian Housing Register, Victoria, 2018–19

Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store, Victorian Housing Register 2018–19.

Notes: *The number of people on the Victorian Housing Register includes people whose application was approved or escalated. ^These people were offered or allocated a moveable unit.

Offers for social housing are currently made in accordance with the Victorian Housing Register's order of prioritisation, taking into consideration the suitability of the property to the applicant's household composition and living requirements.

In order of priority, the Victorian Housing Register's priority access categories are:

- Emergency Management Housing, for individuals and households that have had their housing deemed no longer safe or habitable due to an emergency[99]
- Priority Transfers, for people who are already living in social housing but require relocation to another social housing property due to safety, suitability, re-development or repurposing reasons[100]
- Homeless with Support, for people who are receiving supports in relation to their experience of persistent homelessness or family violence[101]
- Supported Housing, for people who have disabilities or long-term health problems who require physical alterations made to their accommodation and/or the assistance of personal support services to live independently[102]

- Special Housing Needs, for people whose current housing arrangements are no longer suitable and who have no other housing options. Priority reasons under this category include insecure housing, inappropriate housing due to severe overcrowding, instances of family violence and urgent medical needs, which may be a 'psychiatric illness'[103]
- Special Housing Needs for people over 55, for people who meet the eligibility criteria for the Special Housing Needs category but are aged 55 years or over.[104]

While mental illness is acknowledged as a potential priority reason under two of these categories—Supported Housing and Special Housing Needs—it is not emphasised in its wording or weighting. Ms Catherine Humphrey, CEO of Sacred Heart Mission and Chair of the Board of the Council to Homeless Persons stated:

> The State Government has implemented an integrated waiting list for both public and community housing, with priority given to certain groups on the Victorian Housing Register. This helps house those deemed as priority sooner. However, people with severe mental illness are not identified within these priority groups as they are considered within the group of homelessness with support. There may be merit in considering if the priority groups can be extended to mental illness, as well as homelessness with support.[105]

Dr Michael Fotheringham, Executive Director at the Australian Housing and Urban Research Institute, gave evidence that mental illness is a double-edged sword when it comes to obtaining access to social housing:

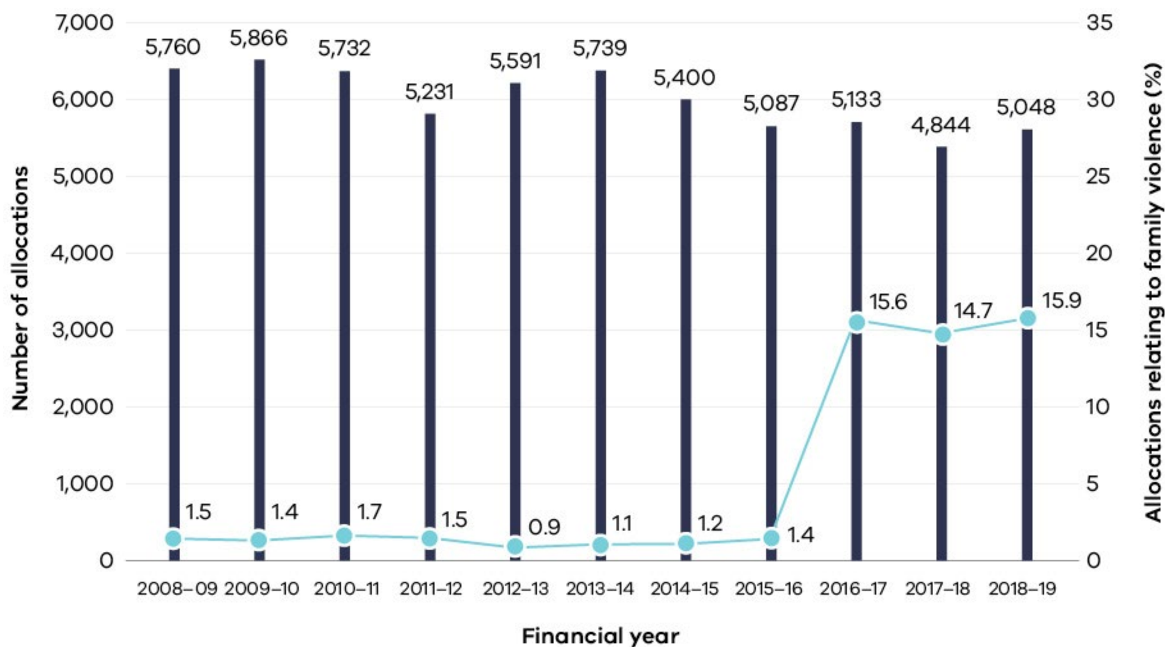
> having a mental health diagnosis may work against persons being allocated a social housing property through community housing providers, as these can be reluctant to accommodate people with high and complex needs … Although diagnosis can open doors to some mental health services and is necessary for accessing the [National Disability Insurance Scheme], it is not enough to help access social housing.[106]

From the perspective of consumers, social housing remains very difficult to access and there is a perception that limited priority is given to people with mental illness. As the Commission heard from one lived experience representative:

> In terms of access to social housing, who knows how you get it, it's a mystery … I'm still on the social housing list and have been for about 10 years … [Mental illness is] so overlooked still, I think with social housing and mental illness. So yeah, I think it does need to be prioritised.[107]

The Royal Commission into Family Violence identified a similar issue for people experiencing family violence, recommending that the Victorian Government remove blockages in the current housing system to ensure this cohort is able to gain stable housing as quickly as possible.[108] This had a significant and immediate impact on the number of people experiencing family violence who were able to obtain access to housing. Prior to the publication of the Royal Commission into Family Violence's final report in 2016, people experiencing family violence accounted for just 1.4 per cent of all people granted access to housing in 2015–16. Post-2015–16, this increased to 16 per cent, leaping from 69 people to 801 in just one year (as illustrated in Figure 16.3).

Figure 16.3: Number of housing allocations and proportion of housing allocations due to family violence, Victoria, 2008–09 to 2018–19



Source: Department of Health and Human Services, Integrated Data Resource, Victorian Housing Register 2008–09 to 2018–19.

Notes: The percentage of approvals relating to family violence rate is calculated based on approvals recorded with the following reasons: Unsafe housing – family violence; and family violence. The Royal Commission into Family Violence report was tabled in Parliament on Wednesday, 30 March 2016.

The same leap is required for people living with mental illness or psychological distress and especially for those requiring ongoing mental health treatment, care and support. This will ensure the housing needs of people with mental illness are adequately recognised and that an adequate response is provided to cater for those needs.

Accordingly, the Commission recommends that the Victorian Housing Register 'Special Housing Needs' category is revised to include mental illness or psychological distress as a priority reason. The Commission expects that this will result in more people living with mental illness obtaining access to social housing from the housing register waiting list, over and above those who will obtain access to supported housing through the 2,000 dwellings to be developed as part of the Big Housing Build.

16.3.2 Tenancy support services can help to keep people housed

Not only should people living with mental illness or psychological distress be better supported to obtain access to social housing, they should also be better supported to retain it. As described throughout this chapter, people with mental illness can have difficulty retaining stable housing for various reasons, including loss of independent living skills, limited financial resources and fluctuating mental health issues.[109] As the Commission heard from one consumer, 'whether it's private [housing] or not, it's hard to maintain a tenancy when you've experienced homelessness and the associated traumas.'[110]

Ms Jenny Smith, CEO of the Council to Homeless Persons, also presented evidence that:

> even if someone in those circumstances obtains an affordable housing option, the impact of the psychosocial disability can cause difficulty in sustaining that housing. For example, depression can lead to low motivation to perform the tasks required to successfully sustain a private rental property, while agitation can lead people to behave in ways that contravene standard rental agreements.[111]

There is also evidence to suggest that some public housing providers and tenancy managers do not have the necessary skills, knowledge or capacity to detect or support tenants when they are experiencing mental health issues.[112] This has been identified as a contributing factor to the higher rates of tenancy loss among people living with mental illness or psychological distress, compared with those without, as they are not able to receive the necessary support or leniency in their rental agreements during periods of crisis or fluctuating mental health.[113]

As noted by Dr Pollock:

> A good tenancy manager can be the difference between a successful tenancy, or an eviction … Knowledge of mental health, triggers for deterioration and early intervention when problems arise, how to work in ways that are supportive and when to escalate to specialised support can all be implied from the [Trajectories] study. Conversely, the research demonstrated that when people are treated badly by tenancy managers, through rude behaviour and/or administrative incompetence, this has a negative impact on mental health and is not effective in helping people manage their tenancy.[114]

The Productivity Commission's *Mental Health Inquiry Report* also concluded that:

> Social housing workers and real estate agents play an important role on the ground to support people to maintain their tenancies. These frontline housing workers are often the first to identify vulnerable tenants and can then link tenants with supports. However, in many cases, there is a lack of understanding and knowledge within these roles to identify, monitor and respond to housing issues among people with mental illness … This lack of awareness extends to the private rental market, where it can lead to discrimination against prospective tenants with mental illness, potentially preventable evictions and, in some cases, blacklisting from future rental properties.[115]

Many consumers and sector providers have highlighted to the Commission that without access to adequate and ongoing tenancy support delivered alongside mental health and other social supports, people with mental illness are at high risk of losing their housing.[116]

This view is supported by the findings of a recent research project undertaken by a Victorian housing support service, Unison Housing. The research indicated that people leaving psychiatric inpatient facilities and going to social housing are at high risk of losing their tenancies early and often are not able to stay for longer than 18 months.[117]

Specialised tenancy support services that are tailored to the needs of people living with mental illness or psychological distress have demonstrated success in Victoria. For example, Wellways, a non-government mental health organisation, delivers a targeted tenancy support service called Doorway for people with mental illness in Victoria. Doorway supports people experiencing mental health issues who are homeless, or at risk of becoming homeless, to access and retain stable housing in the private rental market.[118]

Operating in partnership with area mental health services, the Doorway program enables participants to choose and access their own accommodation through subsidised rent packages and provides ongoing and coordinated support to help them develop independent living skills and maintain good mental health.[119] An independent evaluation of the program in 2014 reported improved mental health, housing, social inclusion and employment outcomes for participants. On average, participants demonstrated reduced contact with acute mental health services, maintained stable accommodation and reported feeling more independent and having greater levels of self-respect.[120]

Despite the efficacy of this program and mental health–related tenancy support services more broadly, specialised tenancy support services that are tailored to the needs of people experiencing mental health issues are limited in Victoria.

From Ms Humphrey's perspective:

> We tend to have a set and forget mentality of getting someone housed and our job is done and our belief is that it's actually not done; that's when the hard work starts about keeping people housed, so that practice development around sustaining tenancy support is really critical … the sustaining tenancies' role should pick that up early and avoid people's housing breaking down.[121]

Tenancy support services can be highly valuable, particularly when delivered alongside other mental health, general health and social supports. The Commission encourages the Victorian Government to progress the ongoing delivery of these services for people living with mental illness or psychological distress across all parts of the housing system.

Ultimately, regardless of where a person with mental illness is living—whether it be in social housing, private rental or supported housing arrangements—it is essential that the future system delivers the necessary range of mental health, wellbeing, social and tenancy supports that will help them to make a house into their home, now and into the future.

16.4 Investment in more long-term supported housing is needed

The lack of specialised long-term supported housing options for adults living with mental illness or psychological distress and who require ongoing treatment, care and support is a critical gap in the current system. This reflects a critical finding of the Productivity Commission's inquiry into mental health.[122] The Productivity Commission recommended that '[w]ith support from the Australian Government, State and Territory Governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness.'[123]

Many have raised the need for a significant expansion of Victoria's supported housing infrastructure for people living with mental illness or psychological distress and who require ongoing treatment, care and support.[124] For example, as described by Ms Sandy Jeffs OAM, a witness before the Commission:

> a place to call home is the missing link in the mental health system. Where people are offered clinical support for their mental illness and social support to help them stay in the accommodation … I can't stress enough how valuable it is to have a place to call home … Having a place to call home gives people a sense of hope and a sense of worth—that they are worth a home; a place to call home … It is incumbent on a government to supply people with affordable and supported accommodation. If a person needs support—clinical support, support in going to an appointment, or support in managing their health for example—this should be provided.[125]

This view is shared by many sector providers, including Dr Pollock, who stated that:

> The mental health system has no medium or longer-term offerings that combine housing and support for this cohort of people. The facility-based rehabilitation support that is available in Victoria through Prevention and Recovery Centres (PARC), including the extended PARC, is good. But there is still a significant gap between acute and sub-acute inpatient care and access to and availability of, long-term supportive housing and/or other support for housing and tenancy management available through the [National Disability Insurance Scheme].[126]

Case study:

Housing and Accommodation Support Initiative

Under New South Wales' Housing and Accommodation Support Initiative (HASI), community-based community support providers work in close partnership with local mental health teams to deliver flexible wellbeing supports and practical assistance to people who experience mental illness so that they can live and participate in the community, maintain successful tenancies and continue their recovery.

The foundation of the HASI program is the partnership between NSW Health, Housing NSW, community support providers and community housing providers. NSW Health is responsible for delivering clinical services (via local health districts) as well as funding the wellbeing support services that are delivered by community support providers. The community support providers work closely with government and community housing providers that manage the tenancies of HASI consumers who live in social housing. The HASI program also delivers targeted support packages to people living with mental illness who are living in private tenancies.

Services are tailored to the individual support needs of each consumer and involve consumers in decision making.

Since its establishment in 2002, HASI has evolved and expanded. Originally providing 100 support packages, it now supports more than 1,900 people under a flexible support model. Changing its model from 'packages' to hours of support has given HASI flexibility to adjust supports to meet changing consumer needs.

The evaluation of the HASI program in 2012 concluded that consumers receiving HASI had greater tenancy stability and used their relevant mental and physical health services more, leading to better mental health outcomes, social contact and participation in community activities, including education, training and work.

In addition, the evaluation found participants had significantly fewer and shorter mental health hospital admissions, leading to an associated cost saving and increased capacity for other consumers. Improvements included a 59 per cent decrease in the average number of days spent in a mental health inpatient unit per year and a 24 per cent drop in the number of admissions to hospital per year.

One HASI participant spoke about how they benefited from the program:

> Without [the HASI Support Provider] I wouldn't be in as good a place as I'm in now, not just physically but having achieved some of the things I wanted to achieve—like my independence in living and in running my own life and stability in housing.

In 2012, the annual per person cost of HASI was calculated to be between $11,000 and $58,000. These figures do not include the cost of clinical mental health services, the costs to social housing providers (as these costs would be incurred regardless of HASI participation) or project management costs. Between 2002 and 2007, there was an initial social housing capital investment of $26 million. Since this initial capital investment, housing acquisitions specifically for the program have ceased and HASI uses housing provision through social housing and private tenancies.

A follow-up evaluation of HASI and related programs is expected in 2021.

Source: RCVMHS meeting with NSW Health, 11 September 2020; NSW Health, *Correspondence to the RCVMHS*, 2020; Jasmine Bruce, Shannon McDermott, Ioana Ramia, Jane Bullen and Karen R. Fisher, *Evaluation of the Housing and Accommodation Support Initiative (HASI) Final Report*, 2012.

16.4.1 Effectiveness of mental health supported housing models

While the Commission welcomes the Victorian Government's commitment to develop 2,000 new dwellings for Victorians living with mental illness, the provision of housing alone will not be sufficient to meet the needs of this cohort. The Commission recommends that these dwellings must be delivered as supported housing. Supported housing models operate at the interface between housing and mental health service systems—as permanent tenancies in individual or shared-living arrangements, with appropriate levels of integrated and individually tailored mental health and wellbeing support.[127]

Supported housing will form a core component of the extended rehabilitation pathway to be established in the reformed mental health and wellbeing system, as described in Chapter 10: *Adult bed-based services and alternatives*. As noted earlier, the future system will deliver an extended rehabilitation pathway to meet the housing and support needs of a group of people living mental illness or psychological distress and who require ongoing treatment, care and support (including those requiring ongoing intensive supports) to lead a contributing life.

Supported housing models cover a spectrum of housing and support configurations that reflect the various support needs and preferences of different consumer groups.[128] For instance, supported housing models can range from single-person apartments scattered throughout the community with off-site visiting support staff, through to shared living arrangements for multiple residents in independent units on a single-site residential property with 24/7 on-site staff support.[129]

Various forms of supported housing programs have been implemented internationally and in Australia, including Queensland and New South Wales, with demonstrated effectiveness for mental health consumers and for the mental health and housing service sectors more broadly.[130]

At Home/Chez Soi, which commenced in Canada in 2008, is an internationally recognised model of effective supported housing for people living with severe mental illness, as well as experiencing homelessness.[131] Adopting a 'housing first' approach, this program enabled rapid access to stable housing without any preconditions.[132] In other words, consumers did not have to engage in other support services or demonstrate recovery from substance use or addiction issues to access the program.[133]

The service was delivered as private rental housing—predominantly in the form of single-person apartments with some shared-living offerings—with integrated onsite support, comprising case management, mental health, addiction and social supports.[134] Evidence suggests that participants demonstrated increased quality of life, greater community integration and accelerated recovery outcomes, relative to those who did not have access to supported housing.[135] A key finding of the program was that while the housing first approach is a 'sound investment' and 'rapidly ends homelessness', it is important to recognise that 'it is Housing First, it is not housing only', meaning that housing must be closely linked to mental health treatment, care and support to meet the needs of this cohort.[136]

Housing models in Australia include South Australia's Housing and Support Program,[137] Queensland's Housing and Support Program,[138] and New South Wales' Housing and Accommodation Support Initiative (HASI).

In Victoria, there are limited supported housing options for people living with mental illness or psychological distress. Victoria's Housing and Support Program, which was established in 1993, was decommissioned 10 years later.[139] Those options that do exist and were highlighted to the Commission include Common Ground[140] and the Haven Foundation program.[141]

Common Ground is delivered by community housing provider, Launch Housing. It provides 65 self-contained apartments on a single-site property and 24-hour support to residents with a history of homelessness and ongoing support needs, including mental health issues.[142] The Haven program is operated by non-government mental health organisation, Mind Australia.

16.4.2 Inequities remain in the National Disability Insurance Scheme for Victorians living with mental illness

The National Disability Insurance Scheme (NDIS) delivers three types of housing-related supports to people with 'permanent and significant' disability across Australia.[143] The role and structure of the NDIS is explained in detail in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

These housing-related supports are:

- Specialist Disability Accommodation funding, which covers the capital costs associated with a specialised housing solution for participants with extreme functional impairment and/or very high support needs[144]
- Supported Independent Living funding, which covers supports designed to assist people to live independently in a shared living environment; it does not include the capital costs of the physical property, rent or other day-to-day living expenses[145]
- Individualised Living Option funding, which covers flexible support options for people who are not in a shared living arrangement with other NDIS participants.[146]

Participants are also able to direct core supports in their plans towards living independently and safely.[147]

The NDIS provides specialist disability supports to people experiencing permanent and significant disability to support them in activities of daily living.[148] As at 30 June 2020, there were 13,412 active NDIS participants in Victoria with a primary psychosocial disability.[149] On average, participants with a primary psychosocial disability account for approximately 13 per cent of all disability groups within the NDIS in Victoria.[150] The National Disability Insurance Agency (NDIA) uses the term 'psychosocial disability' to describe enduring disabilities arising from a person's experience of mental illness[151] and 'primary psychosocial disability' when a person's main disability is mental illness.[152]

In its 2018 Specialist Disability Accommodation Investor Brief, the NDIA stipulates '6% to be the best current estimate of the number of participants who will be found eligible for [Specialist Disability Accommodation] funding under the NDIS'.[153]

Case study:

The Haven Foundation

The Haven Foundation is a Victorian Community Housing Provider that, in partnership with Mind Australia, provides long-term housing, care and support for people living with severe and enduring mental illness. The program recognises that secure, affordable housing offering on-site care and support along with family and carer involvement is a critical aspect of recovery for many people.

The program was established by the Haven Foundation (now part of Mind Australia) and has two sites, in South Yarra and Frankston. Five new sites—in Geelong, Laverton, Epping, Pakenham and Mooroopna—are expected to be completed in 2021.

The South Yarra site has space for 14 people and the Frankston site has space for 18 people. Each resident lives independently in their own apartment with kitchen, laundry and bathroom facilities and an outdoor area.

To join the program, a person must be eligible for social housing, be a National Disability Insurance Scheme participant, be aged over 18 years and have no dependents. They must have severe mental illness and an associated level of disability that cannot be met by alternative housing and support options.

Residents receive 24/7 on-site support from qualified and experienced community mental health practitioners, including peer workers. Mind's My Better Life Plan also supports residents to identify and achieve their goals of recovery. These services are funded by the National Disability Insurance Scheme as Supported Independent Living. The Haven Foundation provides property management services, but rent is managed and collected via Housing Choices Australia.

Ms Elizabeth Byrne is a founding member of Haven. In 2005 she came together with other parents in a shared commitment to address the need for long-term housing for people with enduring mental health conditions.

> Our unique model of care incorporates the participation of residents, family/carers, support staff and volunteers as key partners in service planning, delivery, monitoring and evaluation.

In late 2016, the Haven Foundation recognised the need for all families to be involved in the on-site activities and decision making of Haven South Yarra, and merged their managing committee with the local family group to become the Haven South Yarra Family Hub. Ms Byrne said there will be a Family Hub at each Haven Foundation site to help promote a safe place for families, carers and supporters to support each other with their shared challenges.

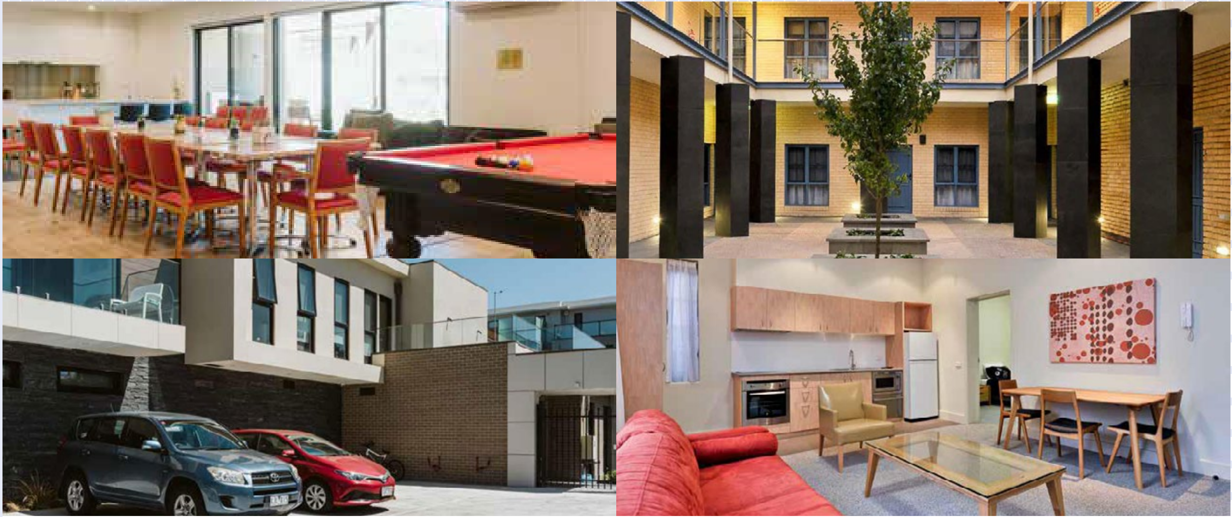


Photo credit: The Haven Foundation

> There will be a wealth of experience and skills brought to the Haven from the support staff, residents, family/carers and volunteers.

Ms Byrne said this mutual support helps to create a home and a community for residents, as well as hope, health and happiness.

An independent evaluation by Monash University in 2013 noted that the Haven South Yarra is a unique model offering certainty and stability of housing to people with severe mental illness. It concluded that tenants experienced a reduced need for acute psychiatric or residential rehabilitation care, greater participation in vocational or educational opportunities and improved their connections with carers and family members as well as members of the broader community.

Residents also said they valued the stability of their tenancy and the ability to personalise their space and use it as a base to enjoy community activities. These activities include tennis, a community garden and a coffee club. Residents said that they look forward to these regular social activities.

One resident of the Haven Frankston said being able to live independently but with support available when they needed it assisted them in their recovery.

> There are group activities to participate in here at Haven, but the wonderful thing is that all the residents have their own space and choose what they want to take part in or what support they need—we all have the chance to actively work on our recovery alongside one another and Mind staff, which I'm finding so very helpful. I had never heard of supported independent living before, but I feel so fortunate to have been offered a place here.

Source: RCVMHS, *Interview with Elizabeth Byrne,* November 2020; The Haven Foundation, Our History, <havenfoundation.org.au/our-history>, [accessed 22 October 2020]; Stuart Lee and others, *Exploring the impact of housing security on recovery in people with severe mental illness Summary Report*, 2013 <www.mindaustralia.org.au/sites/default/files/Exploring_the_impact_summary_report.pdf>; The Haven Foundation, A Haven for Heather, <www.havenfoundation.org.au/a-haven-for-heather>, [accessed 22 October 2020].

Applying this 6 per cent estimate to the Victorian population, Dr Pollock concluded that:

> Using the Productivity Commission's estimation that there would be around 64,000 people with primary psychosocial disability in the Scheme once it reached capacity, we would expect to see around 4,000 people with primary psychosocial disability in [Specialist Disability Accommodation] funded homes.
>
> Given that Victoria accounts for around 25% of the Australian population, it is reasonable to assume that around 1,500 of these people would live in Victoria. The figures we are currently seeing from the NDIA fall far short of this. As far as we know, there have only been 348 people across Australia who have [Specialist Disability Accommodation] on the basis of psychosocial disability and the majority of those have come from one institution in New South Wales.[154]

The NDIA advised the Commission that 151 out of the 13,412 participants with a primary psychosocial disability in Victoria have Specialist Disability Accommodation in their plan and 266 have Supported Independent Living in their plan.[155] The Commission was also told that out of the 4,825 participants with a primary psychosocial disability in Victoria who entered the NDIS in 2019, only 45 were allocated Specialist Disability Accommodation in their plan (0.9 per cent) and only 71 were allocated Supported Independent Living funding (1.5 per cent).[156]

There is further evidence to suggest that NDIS expenditure on housing-related supports for Victorian participants with a primary psychosocial disability is limited. As at 31 March 2020, the NDIA advised the Commission that a total of just $60 million had been committed to Supported Independent Living funding and $37.8 million to Specialist Disability Accommodation funding for Victorian-based participants with a primary psychosocial disability. This compares with more than $540 million in Supported Independent Living funding and approximately $560 million in Specialist Disability Accommodation funding for participants with other forms of disability in Victoria.[157]

Notably, allocation of Specialist Disability Accommodation in a participant's plan does not translate directly into access to a property. The market plays an important role in ensuring that properties are available.

The Commission can deduce three overarching reasons for the NDIA's underspend on Specialist Disability Accommodation for NDIS participants with a primary psychosocial disability. Specifically, that fewer people are granted access to the NDIS for mental illness compared with other forms of disability;[158] the access requirements for Specialist Disability Accommodation do not reflect the needs of people with psychosocial disability;[159] and market failures have led to shortages in housing stock.[160]

Acknowledging steps already taken by the NDIA to reform the current operations of the NDIS to better reflect the support needs of people living with mental illness,[161] the Commission calls for further reform. For many people living with mental illness in Victoria, the application process for NDIS housing support is convoluted and complex, with a number reporting that it is too difficult to access.

At a consumer focus group, a person shared with the Commission that:

> [Specialist Disability Accommodation] funding is so, so hard to get. I didn't even know that it was an option for people that are on the [NDIS] for mental health reasons. We have a client who's just recently had a leg amputation [and] has intellectual disabilities and mental health disabilities and still did not receive the funding for [Specialist Disability Accommodation] ...[162]

As a high priority, the Commission calls for further revision to the access requirements for Specialist Disability Accommodation to better reflect the needs of people living with mental illness, not just physical disability. Although a person living with mental illness and high-intensity support needs may not require certain structural elements—such as ramps or wide doorways—on which Specialist Disability Accommodation solutions are currently based,[163] specialised housing solutions are essential to their ability to lead an independent and meaningful life. This cohort might require access to garden space, soundproofing, the provision of sensory rooms and adequate living and visiting spaces for carers and supporters.[164]

Factors contributing to the undersupply and limited diversity of housing stock also include:

- a lack of important information regarding current levels of supply and competing demand[165]
- uncertainty around long-term pricing and return on investment for private developers and investors[166]
- a lack of understanding about the cohort of people it is designed to support.[167]

The Victorian Government has a critical role to play in improving access to NDIS-funded Specialist Disability Accommodation and Supported Independent Living for people living with mental illness and who need ongoing intensive treatment, care and support.

According to Ms Smith:

> The overarching question here is: what do we all need to do to make the [Specialist Disability Accommodation] realise its potential for people experiencing severe mental illness and housing insecurity or homelessness? From what I understand on the housing provision side is that the [Specialist Disability Accommodation] opportunities are largely taken up by large private developers ...[168]
>
> Community housing, which is the NGO social housing provider, should have a big role in this space, but it does not. They are not large enough or wealthy enough to take on the risk of this type of development. Thought needs to be given to what structures can be put in place to support them being involved because they would be a more natural landlord than the private sector due to their focus on providing housing that is affordable for people on low incomes.[169]

Personal story:

Geoffrey

Geoffrey* is a father of four and the carer for his son Ian.* Geoffrey and Ian live in regional Victoria. Ian is 20 years old and has an intellectual disability and autism spectrum disorder. He has also been diagnosed with mental health conditions including schizophrenia and obsessive compulsive disorder.

Geoffrey recalls first noticing Ian's mental health issues when he was 13 years old. By 16 years old, Ian's mental health had deteriorated and he was becoming aggressive.

> We tried contacting probably a dozen psychiatrists, begging them to see [Ian] because we felt something was very, very wrong, but we couldn't get any help.
>
> When we told them that he was autistic and had an intellectual disability, they pretty much all ran for the hills, except one psychiatrist said, 'I'll put him on my waiting list'.

After waiting more than six months, they saw the psychiatrist and he assessed Ian as experiencing psychosis.

> He told us [Ian] is responding to psychotic episodes; he's responding to things that aren't real.

Geoffrey said despite Ian starting treatment, his behaviour escalated and he was admitted to his local adult psychiatric inpatient unit, despite being only 16 years old. Geoffrey said Ian responded well to treatment and was discharged. However, when he deteriorated again about seven months later and tried to seek a readmission he was turned away.

> He was indicating 'my head hurts, my head hurts; take me to a hospital please Dad' and crying. Since then, the psychiatrist has said he thinks this is [Ian's] way of telling you that he's seeing things and he's not sure if they're real. But we couldn't get a readmission, which was nothing short of disgusting.

Not long after this, during a psychotic episode, an incident occurred involving police intervention. Ian was then readmitted into his local adult inpatient unit, and then transferred to an adolescent inpatient unit in Melbourne. Geoffrey said this was where he received the best treatment and care, with daily visits from the psychiatrist, and Ian was able to complete some schooling at the unit.

But once Ian was ready for discharge, Geoffrey says there was nowhere for him to go, so Ian was stuck in hospital. Child protection services had become involved and assessed that it was not safe for his siblings for Ian to be in the family home.

Due to Ian's needs, Geoffrey began the application process with the NDIS so Ian could access supported accommodation. This was delayed due to Ian initially being deemed ineligible for the NDIS, which was appealed, and then there were waitlists to access the supported accommodation.

> The NDIS package took six or seven months to get approved. And that was why he was on that ward for so long as he was ready to be discharged after five or six weeks.

Ian was still in the inpatient unit, even after passing the age limit on his 18th birthday. Eventually, he was discharged when he was given access to live in an NDIS-funded shared Specialist Disability Accommodation with the support of a community mental health support provider.

Geoffrey has concerns about Ian's wellbeing if he requires a future admission and feels that the adult inpatient unit would not meet the needs of a young adult with both mental health challenges and disability.

> Our biggest fear is if he becomes mentally unwell again and needs a readmission to hospital, we are so concerned for his safety.

Geoffrey says despite many difficult years, Ian is on a good trajectory and is currently receiving good support. In a future system, Geoffrey would like to see more services for people with co-occurring disability and mental health challenges.

> It's with great sadness that we don't have an inpatient unit for young people between 18 and 25 with dual disability.

Source: RCVMHS, *Interview with 'Geoffrey' (pseudonym)*, November 2020.

Note: *Names have been changed to protect privacy.

The Victorian Government should advocate at a Commonwealth level for further reform in the NDIS to eliminate these clear inequities for people with psychosocial disability, as well as engage more heavily in the local Specialist Disability Accommodation market to boost the supply and diversity of housing stock. This might involve one-off investments in new Specialist Disability Accommodation stock, or risk-sharing arrangements with potential investors and providers.

The personal story of Geoffrey and his son Ian demonstrate the consequences of the current shortfalls in the NDIS, and the critical lack of Specialist Disability Accommodation specifically, on people living with mental illness, their family, carers and supporters and the mental health and wellbeing system more broadly.

16.4.3 Delivering a range of supported housing options

As previously noted, the Victorian Government has assigned 2,000 social and affordable housing properties to be developed as part of the Big Housing Build to Victorians living with mental illness. The Commission expects these 2,000 properties to be delivered as supported housing and eligibility to be guided by consumers' level of independent functioning. The Commission expects priority access to be given to people living with mental illness or psychological distress and who require ongoing treatment, care and support, as well as those with ongoing intensive treatment, care and support needs. Area Mental Health and Wellbeing Services are to be involved in the selection process.[170]

Specifically, the Commission considers that access be given to:

- long-stay consumers in an acute inpatient setting who are unable to be discharged due to a lack of appropriate discharge options
- individuals who are experiencing long-term homelessness or are at high risk of becoming chronically homeless
- individuals who have highly unsustainable or unsafe living arrangements with friends, families, carers and supporters.

The typical referral pathway into supported housing will be through the new integrated community mental health services, where comprehensive care planning and coordination will occur and support needs identified.

The supported housing must be safe, secure and affordable and delivered in a wide variety of housing configurations across metropolitan Melbourne and regional and rural Victoria. It is clear to the Commission that a one-size-fits-all approach does not work when it comes to housing for people living with mental illness or psychological distress. Giving a person a sense of control over their living arrangements, including tenure, location and composition, is important to normalise the housing experience, establish a sense of home and to foster a sense of dignity.[171]

Professor Fisher emphasised that:

> The housing needs of most people with severe mental illness are the same as for any other citizen, which is affordable and accessible housing in a place that is convenient to the person with transport options and that promotes their social connections.[172]

In accordance with Article 19 of the United Nations Convention on the Rights of Persons with Disabilities, prospective residents of supported housing must 'have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement'.[173]

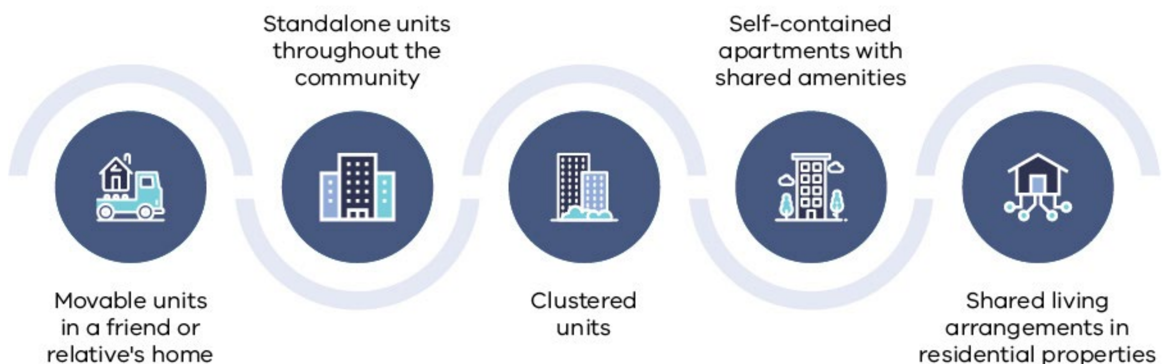
A wide variety of housing configurations and locations will therefore be required to meet the various living needs and preferences of people living with mental illness or psychological distress.[174] The Commission understands that while some people will prefer to live in a standalone unit in the community or a portable unit in a friend or relative's home, others might prefer the privacy afforded by a self-contained apartment with access to shared living spaces and amenities.[175]

As reported to the Commission by one consumer:

> **The ideal is to have multiple options of both for people. For myself, I like being independent and being separate from things, but to have that and it be supported that would be ideal. For other people, they need to know that there are people around them that are not just support workers.**[176]

The 2,000 dwellings to be delivered as part of the Big Housing Build must span standalone units throughout the community, movable units in a friend or relative's home, clustered units on a single-site property, self-contained apartments with shared amenities and shared living arrangements in residential properties, as illustrated in Figure 16.4. The optimal composition and design of these housing types should be determined through a thorough co-design and planning process by Homes Victoria, representatives appointed by the Mental Health and Wellbeing Division and people living with mental illness or psychological distress.

Figure 16.4: Range of housing prototypes that the long-term supported housing should deliver



The dwellings must reflect contemporary physical designs that are sensitive to the unique needs of people living with mental illness or psychological distress. This includes access to adequate natural lighting, garden space, adequate privacy and soundproofing.[177] The housing also needs to be in close proximity to local amenities, such as shops, public transport and support services. Ongoing research should be conducted to understand the features of optimal therapeutic design for people living with mental illness or psychological distress.[178]

Reflecting on their experiences in a supported housing setting, one consumer told the Commission:

> **The accommodation itself needs to be different for people with mental illness. For example, clean surfaces, because I had to become re-domesticated. Accommodation needs to be thoughtful of mental health considerations.[179]**

Dwellings must be appropriately located. Where possible, people must be placed within, or close to, their own community, to mental health and related services and established support networks. The housing should also be integrated into residential properties or neighbourhoods to avoid instances of stigmatisation, isolation or segregation.[180]

As told to the Commission by one consumer:

> **Supported accommodation cannot stick out like a sore thumb and needs to be integrated into residential streets. [The government] [c]annot keep ostracising vulnerable people. The more we integrate vulnerable people, the greater recovery will be. I still feel very stigmatised and that comes down to aesthetics, postcode, address, what comes up when you look it up.[181]**

Where clustered and shared living arrangements are employed, the Department of Health has a duty to ensure that the scale of units on a single site does not compromise the independence of residents and their integration and connection with the broader community; and that it does not 'mimic living in an institution'.[182] The need for places that offer 'asylum in the best sense not in the old sense of psychiatric hospital asylums' in the future mental health and wellbeing system is explored in Chapter 10: *Adult bed-based services and alternatives*.

Supported housing must be safe for all residents. At a minimum, residents will need to have access to adequate privacy, control over their personal space and readily available support as required.[183]

Specific housing solutions must be available for certain population groups with additional support needs and living requirements, including families with young children, women and gender-diverse people (which refers to a range of genders expressed in different ways),[184] Aboriginal and Torres Strait Islander people and individuals with dual disability. Dual disability describes a mental illness alongside an acquired or neurodevelopmental disability, such as an intellectual disability, autism spectrum disorder or attention-deficit/hyperactivity disorder.[185] The Victorian Government must engage the relevant cohorts in a co-design process to ensure the specific housing solutions reflect their housing and support needs.

16.4.4 Supports must be flexible, individualised and integrated

For many people, supported housing will represent their first stable home.[186] Years of repeat service system failures, mental health issues and chronic homelessness can erode a person's independent living skills,[187] financial resources,[188] social connections and support networks[189] and their overall sense of self.[190]

The support component of the supported housing must be flexible, delivered by multidisciplinary teams through Area Mental Health and Wellbeing Services and able to be tailored to the individual support needs of each resident. Beyond clinical mental health supports, such as medication, common support needs will include practical assistance to develop independent living and social skills, re-establish relationships and community connections and provide alcohol and other drug support.[191] Critically, treatment, care and supports must be recovery-oriented in approach, meaning that residents are supported to pursue their own areas of interest and recovery goals.[192]

The Commission recognises that the fluctuating nature of mental illness means that some residents may require a crisis or emergency service response or an admission to an acute mental health service setting at various points. Streamlined escalation pathways must be established to support continuity of care and minimise any stress caused to the consumer, as well as their families, carers and supporters in such instances. Those pathways must provide for de-escalation into supported housing, while ensuring consumer access to stable supported housing is preserved. The Commission also expects this cohort to benefit from new and expanded bed-based service initiatives, including Hospital in the Home services. These initiatives are set out in Chapter 10: *Adult bed-based services and alternatives*.

Many consumers have emphasised the loss of independent living skills that often accompanies long periods of housing instability or homelessness. As reported to the Commission by one consumer, who is currently living in a form of long-term supported housing:

> The first night here I didn't sleep on the bed because it felt too good for me ... we have to sort of redevelop a lot of skills ... If you've lived rough ... you haven't cooked for three years you haven't done laundry in three years. You haven't done dishes; you haven't vacuumed the house. All these skills have disappeared.[193]

This view is shared by many mental health and housing support sector providers, including Ms Humphrey, who noted:

> We need to help people develop the independent living skills of managing a home because often they've not had to do that, whether that's paying bills, cleaning, whether that's establishing a tenancy, all those things that you and I can take for granted are really important.[194]

The supported housing model will have a strong focus on relationship building and community connection. Social connections and informal support networks are often a casualty of housing instability and homelessness, leaving many people socially isolated without informal supports. As shared by one consumer:

> People with mental health issues [often] don't have a very good [informal] support system ... so to have that ongoing support is really valuable [and] just to be heard as well ... sometimes you might not even realise something is an issue until you raise that said issue.[195]

The same consumer also emphasised the importance of having opportunities to build relationships and community connections with people outside of the supported housing environment, particularly when they are housed in neighbourhoods that they are less familiar with.[196] This might be facilitated through community-based activities—such as volunteering, art classes and singing groups—and re-engagement in employment, in line with the individual preferences and interests of each person.

For many residents, pets will be an important part of their support. In a Melbourne-based study conducted by Professor Ellie Fossey and others into the housing experiences of people with mental illness or psychological distress, pets were highlighted as an important source of companionship, security and emotional support.[197]

As reported to the Commission by Dr Pollock:

> The connection between a person and their animal is really important in terms of that person's emotional health ... For people with social anxiety, quite often the dog is the thing that gets you out of the house; the dog is the thing that enables you to go down to the shops; the dog is the thing that enables you to go out for a walk and actually maintain your physical health. And, when there are prohibition on pets in rental properties it's a real problem ...[198]

Assistance dogs, or psychiatric assistance dogs, also function as an evidenced-based form of support for some people living with mental illness or psychological distress. Assistance dogs have been shown to be particularly beneficial for people experiencing post-traumatic stress disorder. They can provide a sense of comfort and safety, reducing the impact of anxiety-related symptoms and facilitating community connections.[199] Acknowledging that some residents will prefer to live in pet-free environments, specific housing solutions must be made available to them, with the large majority expected to allow pets.

The wide range of support types available to residents will be delivered through a partnership between Area Mental Health and Wellbeing Services, community housing and homelessness service providers, as well as consumers and consumer peak bodies. The operations of the supported housing must ensure that, if residents choose to leave the supported housing, they can retain access to the same level and type of wellbeing and clinical mental health supports, to ensure that continuity of care is maintained.[200]

Given that people will be granted access to supported housing on the basis of ongoing intensive treatment, care and support, it is expected that all residents *should* have access to the NDIS for a primary psychosocial disability.[201] As is the case for the Haven supported housing program, discussed earlier, the provision of non-clinical supports, as part of the long-term supported housing offering, should be funded through the NDIS as Supported Independent Living, the cost of which is met by the Commonwealth. Funding for clinical mental health supports will remain the responsibility of the Victorian Government.

Nonetheless, the Commission acknowledges that a large majority of residents will not have access to the NDIS or Supported Independent Living funding at the point of program entry. Once a person has secured a supported housing place, the Victorian Government should fund advocacy support to facilitate their access to the NDIS, as well as the provision of tailored non-clinical supports in the interim, in addition to clinical mental health supports.

Ms Smith emphasised the need for the Victorian Government, or the NDIS itself, to fund targeted advocacy and coordination efforts to support individuals with primary psychosocial disabilities to access the NDIS:

> It is not always the case that people with psychosocial disability will actually articulate their support coordination needs even if everyone else might think that they clearly would benefit from that ... In homelessness, we call it advocacy: supporting somebody to get what they understand they need, but also assisting them to articulate what might be available for them. That is what is missing.[202]

The Victorian Government should work to establish an agreement with the Commonwealth Government to enable automatic admission of all long-term supported housing residents to the NDIS. This would mirror previous government action taken for people engaged in the Adult Residential Rehabilitation program when the NDIS was rolled out in Victoria.[203]

The Commission recognises that there may be cases where residents do not receive NDIS support. In such instances, the Victorian Government will be responsible for providing the requisite level of integrated and individually tailored mental health and wellbeing supports.

One consumer, Adam Gould, reflected on his lived experience of long-term mental health and housing challenges and the value that safe, secure and truly integrated and holistic supported housing services can have on an individual's mental health and wellbeing.

Personal story:

Adam Gould

Adam has experienced mental health challenges for most of his life. He got an apprenticeship after high school and quickly progressed within the workplace.

> At that stage, I discovered that the way to make friends was to smoke pot. I believe that stress of the job, the sort of pre-existing disposition towards mental health, plus the excessive drug use, tipped me over the edge.

Adam had numerous stays in inpatient facilities and spent years trying to find supports and medication that worked for him.

> It was five years where I was in and out of hospitalisation. Nothing was really working. It's worth noting that to get the medications right, it's taken us 23 years.

Adam was supported to move into crisis accommodation in Adelaide. As things were stabilising for Adam, his mother got sick and he returned to Melbourne to be with her.

> I basically upped stumps and packed everything I could into my backpack and moved up to Melbourne on a bus. I had nowhere to live, so a friend and I set up a squat.

Uprooting his life to move back to Melbourne had impacts for his mental health and his housing. Adam's relationships with others he was living with were strained, and compounded by a range of issues related to substance use and mental health challenges. Adam says that at one point he called an ambulance.

> They turned up about an hour and a half later and I went with them. I was shot full of Valium or diazepam and then released into the wild, no home to go to.

Discharged into homelessness, Adam moved through a number of unstable housing arrangements that were not always appropriate or safe.

> Really dodgy hotels with shared bathrooms and fungus on the walls and after that, they moved me to a rooming house. That was horrifying. As soon as I put my bags down and closed my door, one of my neighbours opened the door and said, 'You got to make your bones; you got to fight me to determine your place in the house'.

Adam moved to more stable accommodation where he has lived for a few years. During this time, Adam has continued to receive mental health support, and has taken actions to limit his exposure to others who are misusing substances and not connecting with support services. He has seen people come and go through services with various outcomes, not all of them good.

> It's a real heartbreaker. I used to watch cowboy films when I was young, and they're like, 'he died with his boots on'. And I look at a lot of people who sleep rough and have a hard time or have substance issues and I'd rather they die with their boots off in a comfortable bed in safety and feeling secure.

Adam thinks that more supports should be provided for people experiencing mental health challenges, substance use and homelessness. He thinks that supports should be holistic, not just addressing one issue, and delivered close to where housing is provided.

> In terms of rehabilitation of people when they move into the building, we really do need to be rehabilitated in a civilised society. I mean, things like washing your clothes, showering. There's so much of the stuff that needs to be retrained and retaught. So it goes beyond just psychological and psychosocial setup.

COVID-19 restrictions have meant Adam hasn't been able to have any visitors to his home or use the site's common areas since March. Adam reflected that compliance with a range of COVID-19 directions and restrictions has been hard to implement in supported accommodation.

> You get in a lift and there's five other people in the lift not wearing masks, and unfortunately, the people doing that are the people most likely to catch COVID. We've got a gentleman who wanders up and down the street picking up cigarette butts and sucking on them. If someone with COVID drops a cigarette butt, he's getting COVID.

Adam is working towards finding stable work and moving out of the supported accommodation.

Source: RCVMHS, *Interview with Adam Gould*, October 2020.

16.5 Giving young people the best chance to lead a contributing life

The Victorian Government has a responsibility to keep young Victorians safe and housed and to ensure they have opportunities to lead meaningful and contributing lives.[204] Yet young people remain prevalent in Victoria's homelessness population,[205] leaving them at increased risk of long-term mental health issues,[206] disengagement from social structures and support networks,[207] trauma and substance use and addiction issues.[208]

The COVID-19 pandemic and the associated restrictions have accelerated the need for immediate housing reform to better support young Victorians. Preliminary evidence suggests that younger Victorians have been disproportionately affected by the economic impacts of the COVID-19 pandemic.[209] The Grattan Institute reports that 'young people have been hit particularly hard', noting that youth unemployment in Australia increased to 16.1 per cent in May, from 11.6 per cent in March. This contrasts with minimal change to the unemployment rate for Australians aged 45 years and over.[210]

In its COVID-19 Recovery Plan for Young People, the Youth Affairs Council of Victoria emphasises that young people are more than twice as likely to have lost their job during the pandemic and that the number of young people experiencing housing stress has almost tripled.[211] The Recovery Plan states:

> This means that thousands more young people in Victoria are likely to experience homelessness over the next ten years as a direct result of the pandemic. There needs to be a coordinated response to end the youth homelessness crisis in Victoria ... If the economic crisis persists as expected there will be a generation of young people who will be unable to afford safe and secure housing for decades to come.[212]

Ms Katherine Ellis, CEO of Youth Affairs Council Victoria, highlighted to the Commission that:

> It will be important to understand the impact of COVID-19 on this generation. Unemployment, underemployment and wage stagnation increases the prevalence of mental ill-health among young people. It disproportionately affects young people from marginalised communities and makes it difficult for young people to afford mental health care without access to free or low cost services. It seems highly likely that those issues will only be exacerbated by this global pandemic.[213]

It is estimated that approximately 4,400 young people aged 19–24 years are currently experiencing homelessness in Victoria, equating to 17 per cent of Victoria's total homeless population.[214] In 2018–19, approximately 1,900 young people aged 18–24 years who accessed a specialist homelessness service were also actively engaged in Victoria's public mental health system, with 700 of them seeking accommodation.[215]

The period of adolescence and young adulthood is an important period of maturation which, if disrupted, can have long-term consequences for the young person, families, carers and supporters and the community more broadly.[216] Evidence suggests that young people experiencing homelessness are more likely to experience mental health issues, disengage from education, lose informal and formal support networks, including family and friends and engage in substance misuse.[217]

As reported to the Commission by youth mental health service, Orygen:

> Compared to other non-communicable diseases, mental illness begins at the precipice of independence and adulthood. It's a time when young people will further their education, forge career pathways, enter the workplace, move away from home and establish key relationships.[218]

One person who experienced mental health issues and homelessness from an early age, reflected that:

> When you experience mental illness and trauma, you don't have a regular development trajectory and it can stunt your growth … Through trauma and mental health [issues], you lose living skills and without those it is really hard to integrate back into society. I am very isolated because I have been unsure of where I fit.[219]

Evidence suggests that the earlier support and housing interventions can be administered to a young person experiencing mental health and housing issues, the greater their chance of recovery and leading a life of value that is not entrenched in repeat homelessness and service system failures.[220]

As summarised by Dr Pollock:

> Invest sufficiently and invest early for the greatest chance for those young people to lead contributing and meaningful lives.[221]

Young people experiencing mental illness and housing instability continue to face critical access barriers to vital supports, including through the mental health system, housing and homelessness support services and the NDIS.[222]

As reported by youth homelessness support services, Melbourne City Mission:

> Young people who present at homelessness services with complex mental health and other issues represent a cohort of young people who have been systematically failed by multiple sectors—across health, education, disability and social services more broadly … Our clients are routinely excluded from clinical services for not meeting the right eligibility criteria.[223]

Angelina's personal story describes her experience of mental illness and housing challenges at a young age, and highlights the importance of having access to adequate, sustained and individually tailored housing and support services.

16.5.1 The future system will deliver more supported housing for young people

Supported housing services have proven to be effective for young people in Australia and internationally. The Youth Foyer program, provided as a case study, is a successful model of supported housing for young people that already operates in Victoria. The Youth Foyer program provides a range of supports to young people aged 16–24 years in a safe residential environment for up to two years.

Case study:

Youth foyers

Youth foyers are integrated support services designed to address the gap in the provision of housing for young people experiencing or at risk of homelessness. Rather than focusing solely on providing emergency housing and crisis support, they make building independent living skills, relationships, social connections a priority, along with community re-integration, which includes linking young people back into education and employment opportunities.

Participants are typically between 16 and 24 years old and they are supported for a period of up to 2–3 years. This allows them to achieve a sense of security and engage in the program. The program recognises that this is a critical development period for young people and if it is disrupted, there can be long-term consequences for their ability to lead a contributing life.

Multiple models of youth foyers exist in Australia and have been developed by individual agencies and government departments. There are several types of youth foyers in Victoria, including those delivered by the Melbourne City Mission and Education First Youth Foyers.

Melbourne City Mission youth foyers
The Melbourne City Mission youth foyer model, funded by the Victorian Government, delivers integrated housing and wellbeing supports. Its capacity ranges from 6 to 21 beds across three facilities. Each youth foyer has self-contained accommodation. Youth foyer staff work with residents to develop care plans that take all of an individual's needs into account and that lead into education and/or employment focused programs.

Wayne Merritt, General Manager, Homelessness, Justice and Family Services at Melbourne City Mission said the youth foyer model helps young people to reduce their dependence on social services gradually.

> We have a high tolerance to be able to support and accommodate young people with multiple and complex needs—the model is designed to provide supported housing and goal orientated programs that leads into education and/or employment focussed programs, and our work is underpinned by our Trauma Informed Healing Oriented framework, which ensure a therapeutic, healing approach to each individual.

Education First Youth Foyers
Education First Youth Foyers are located within TAFE campuses at three locations in Victoria, with each site able to accommodate 40 young people. They are funded by the Victorian Government and are delivered in partnership with housing providers and youth support partners.

The Education First Youth Foyer model, established by the Brotherhood of St Laurence and Launch Housing in Victoria, is designed for young people seeking education and employment opportunities. The aim is to break down the structural barriers preventing them from engaging with these opportunities.

Professor Shelley Mallett, Director, Research and Policy Centre, Brotherhood of St Laurence, noted the model looks at young people's talents, potential and aspirations, rather than focusing on barriers and problems.

> We developed a model based on what we call the capabilities approach and advantage thinking, which looked at realigning the effort around young people around building their opportunities, resources and networks to live lives that they really want to value and to connect them to education, employment and training to enable them to do that.

Source: RCVMHS meeting with Wayne Merritt, 30 September 2020; *Inquiry into Homelessness in Victoria*, Transcript, 23 June 2020; Foyer Foundation, How Foyers Work, <foyer.org.au/foyers-in-australia>, [accessed 21 November 2020]; Melbourne City Mission, Accommodation, <www.mcm.org.au/homelessness/accommodation>, [accessed 21 November 2020]; Brotherhood of St Laurence, Education First Youth Foyers, <www.bsl.org.au/services/youth/education-youth-foyers>, [accessed 21 November 2020].

In addition to the 2,000 dwellings assigned to people with mental illness as part of the Big Housing Build, the Commission has recommended that the Victorian Government invest in a further 500 new medium-term (up to two years) supported housing places for young people aged between 18 to 25 who are living with mental illness or psychological distress and experiencing unstable housing or homelessness.

As noted earlier, it is estimated that approximately 1,900 young people aged 18–24 years who used a specialist homelessness service in 2018–19 were also actively engaged in Victoria's public mental health system and 700 of them were seeking accommodation.[224] Acknowledging that the exact scale of unmet demand for supported housing services for young people is unknown due to a gap in the existing evidence base,[225] the Commission has concluded that at least 500 places are required to meet immediate demand. This is based on information obtained from sector reports,[226] submissions,[227] evidence before the parliamentary inquiry into homelessness in Victoria,[228] witness statements[229] and the Commission's data analysis.[230]

The supported housing will deliver a safe and stable living environment for this cohort of young people, where they can access comprehensive mental health and wellbeing supports that reflect their individual needs, preferences and longer-term aspirations. Supports will be provided by the service stream of Youth Area Mental Health and Wellbeing Services in partnership with community housing and homelessness service providers. As reported by Mission Australia:

> A supportive and stable home environment is a particularly important aspect of a young person's life; it is essential for good physical and mental health and has positive impacts on educational and employment outcomes. Stable housing also provides a platform for access to other supports in the community through school or neighbours.[231]

In line with the youth foyer model, the supported housing will adopt a recovery-oriented approach to care and support, where young people are supported to pursue their own areas of interest and recovery goals. Young people will have access to a multidisciplinary team, including peer support workers, counsellors and non-clinical generalist youth workers. Generalist youth workers deliver care, support and advice to young people about their mental health and wellbeing in relaxed, non-clinical settings.[232] Streamlined escalation pathways will be put in place to ensure that young people are able to use crisis and emergency services or acute mental health treatment, care and support as required. As with adult pathways, pathways for young people must provide for de-escalation into supported housing, while ensuring their access to stable supported housing is preserved.

Ms Ellis highlighted the value that non-clinical generalist youth workers can bring to mental health services for young people:

> an enormous amount of valuable work happens through community programs run by generalist youth workers and community workers ... Investing in more generalist youth workers and community workers will help vulnerable and at risk young people be engaged with skilled workers who are able to identify issues early and provide appropriate support and referrals.[233]

Particular emphasis will be placed on linking young people back into education and employment opportunities, as these are key levers to develop the social and economic resources that will enable them to pursue a meaningful and productive life.[234] The Commission heard from one consumer that:

> when you [are] in the housing and mental health system, because the focus is just getting you into housing or getting you linked with [a] psych, you know, [and] on medication … you lose your sense of identity, and people are not going to flourish if they have no personal identity …[235]

The program will also support young people to rebuild relationships—including with family and friends, wherever possible—foster community connections and develop independent living skills.[236] As outlined in Orygen's clinical guidelines for working with young people experiencing homelessness:

> Young homeless people need a high level of skill to look after themselves, including the ability to source food, find security and find shelter. However, the negative effect that the onset of early psychosis can have on skills development means that young people with psychosis who are also homeless face not only a higher likelihood of a deficit in living skills, but also a higher need for these living skills to survive while they are homeless … Developing skills such as money management, social skills, conflict resolution and problem-solving provides a step towards independent living.[237]

The supported housing will have a strong focus on helping young people to move on to more independent living and secure longer-term housing, which will also function as a source of motivation for many young people. This might involve partnerships with housing support providers or headleasing arrangements, where government rents a property from a private landlord and provides it to low-income tenants at a subsidised rate,[238] to support more streamlined entries for participants into the private rental market at the conclusion of the program.

The supported housing for young people will be delivered in a range of contemporary and co-designed residential settings that reflect the unique needs and preferences of young people. As with the supported housing solution for adults, an element of choice and flexibility will be important. The housing will span shared living arrangements in residential properties, clustered units and self-contained units with shared amenities.

Given the age and developmental needs of participants, ensuring their safety will be a priority. At a minimum, participants will have access to dedicated female and gender-diverse accommodation. Safety must be a key area of focus for the Department of Health during the program's establishment and into the future.

As a new service, the supported housing for young people must be subject to an independent evaluation and periodic review, to ensure it remains fit for purpose and yields the expected outcomes for young people. The optimal scale and distribution of this supported housing must also be subject to ongoing review, as part of the broader statewide and regional planning processes being established by the Commission.

Personal story:

Angelina

Angelina* is 20 years old and lives in Melbourne. She was a victim of family violence throughout her childhood. Her home environment made her feel unsafe, and she found schooling particularly difficult. She has also experienced anxiety and depression.

> My mum was very abusive and manipulative. And there was a lot of domestic violence at home, and it was constant for pretty much 19 years. So that affected me, but I still stayed home, because I was studying full-time, I was working part-time, I had animals at home.

Angelina said that despite telling her school counsellor about her home life, she did not get any help to find safe accommodation and didn't know what was available.

> My boyfriend at the time, his parents let me stay there for about six weeks, so that I could do my VCE year 12 exams in a safe environment.

While studying and living with her father, her mental health declined and she started experiencing psychosis. She was admitted to a Psychiatric Assessment and Planning Unit (PAPU), and then a Prevention and Recovery Care (PARC) service.

> I went to PAPU, which is like a transitionary unit and then I went to PARC and PARC really helped. I didn't know anything about PARC or PAPU in high school, and I would have loved to be in PARC.

The PARC staff discussed alternative housing options with Angelina, and she was pleased to get into short-term youth accommodation. She appreciated the individual support she received, with a safety plan, a care plan and help to find long-term accommodation with mental health support. Angelina has moved eight times during 2020, which has been challenging to juggle with her study.

> The housing situation definitely does impact my mental health. I didn't realise how much it would have, but staying in a refuge has been very helpful.

Angelina is now accessing support from a youth early psychosis program through the public mental health service in her area. In future, she hopes students can access better mental health support through schools and have their stories heard.

> I think children need to have their problems taken seriously, even if they can't express it correctly, or in a way that makes sense.

Source: RCVMHS, *Interview with 'Angelina'* (pseudonym), December 2020.

Note: *Name has been changed to protect privacy.

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Chapter 17

Collaboration for suicide prevention and response

The Commission recognises the strength of people living with mental illness and those experiencing psychological distress, their families, carers and supporters, and members of the workforce who have contributed their personal stories and perspectives to this inquiry.

Some of these stories and the Commission's analysis may contain information that could be distressing. You may want to consider how and when you read this chapter.

If you are upset by any content in this chapter, or if you or a loved one need support, the following services are available to support you:

- If you are not in immediate danger but you need help, call **NURSE-ON-CALL** on **1300 60 60 24**.
- For crisis support contact **Lifeline** on **13 11 14**.
- For phone-based support contact **Beyond Blue** on **1300 224 636**.
- If you are looking for a mental health service, visit **betterhealth.vic.gov.au**.
- **For situations that are harmful or life-threatening contact emergency services immediately on Triple Zero (000)**.

Recommendation 26:

Governance arrangements for suicide prevention and response efforts

The Royal Commission recommends that the Victorian Government:

1. establish in the Mental Health and Wellbeing Division, a Suicide Prevention and Response Office, led by a State Suicide Prevention and Response Adviser who reports to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).
2. enable the Suicide Prevention and Response Office to:

   a. establish a system-based approach to suicide prevention and response efforts;
   b. work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide to co-produce, implement and monitor a new suicide prevention and response strategy for Victoria;
   c. work closely with the Commonwealth Government to ensure suicide prevention and response efforts in Victoria are coordinated with, and complement, national approaches;
   d. facilitate a community-wide and government-wide approach to suicide prevention and response efforts;
   e. work within governance structures that encompass all government departments and relevant agencies, with Deputy Secretary and Secretary level membership; and
   f. employ people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide.

Recommendation 27:

Facilitating suicide prevention and response initiatives

The Royal Commission recommends that the Victorian Government:

1. build on the interim report's recommendation 3 on suicide prevention and response and develop initiatives to support people experiencing suicidal behaviour including:
   a. providing training in appropriate responses for members of workforces likely to come into contact with people experiencing suicidal behaviour;
   b. providing free, online evidence-informed 'community gatekeeper training' for Victorians to develop suicide awareness and prevention skills;
   c. enabling Aboriginal people to design culturally safe 'community gatekeeper training' for Aboriginal people; and
   d. facilitating Victorian industries and businesses to invest in evidence-informed workplace suicide prevention and response programs, with an initial focus on forming partnerships with high-risk industries.
2. develop initiatives to support people at risk of experiencing suicidal behaviour, by:
   a. co-producing an aftercare service for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning people following a suicide attempt; and
   b. in partnership with the Commonwealth Government, implementing statewide postvention bereavement support, so that every person bereaved by suicide is automatically referred to a postvention bereavement provider.
3. develop an intensive 14-day support program for adults who are experiencing psychological distress, modelled on Scotland's Distress Brief Intervention program.

17.1 Suicide prevention and response

Many people have shared their personal experiences of suicidal behaviour and bereavement by suicide with the Commission. It is clear that suicide can affect people across all age groups, from all different backgrounds, for a range of complicated reasons. Suicide has a ripple effect across the community, affecting loved ones, friends, families and colleagues in profound and enduring ways.

Witness Ms Katerina Kouselas, bereaved by the suicide of her husband, told the Commission:

> We had been married for 32 years when Bill passed away. I will never come to terms with that. We were together since we were 18, we have a beautiful daughter, Natalie, and it took my life away and my heart and it will never be okay.[1]

There are many complex factors that can lead to suicide, and these can often overlap. Risk factors contributing to suicide may be immediate-term catalysts, such as job loss or a relationship breakdown, or they may be factors that have been present in a person's life for many years, such as mental illness or a family history of suicide.[2]

Ms Georgie Harman, the CEO of Beyond Blue, told the Commission about the varied factors related to suicidal behaviour:

> Factors that may contribute to suicidal thinking and behaviours include: stressful life events including trauma, poor relationships, homelessness, unemployment and financial stress, mental illness, physical illness, drug or alcohol abuse, and poor living circumstances. By contrast, there are protective factors that make us more resilient and can reduce suicidal behaviour, such as: supportive social relationships, a sense of control, a sense of purpose, positive relationships and family harmony, effective help-seeking, meaningful work and connections to good health and community services.[3]

This means there cannot be a health-only response to suicide.[4] Suicide prevention and response requires a comprehensive effort from the whole community and across government.[5] Many agencies must come together, across health, social services, education, industry and many more, to respond to the interrelating factors that can lead to, or protect against, suicide. This is referred to as a whole-of-government approach and is explored further in section 17.5.

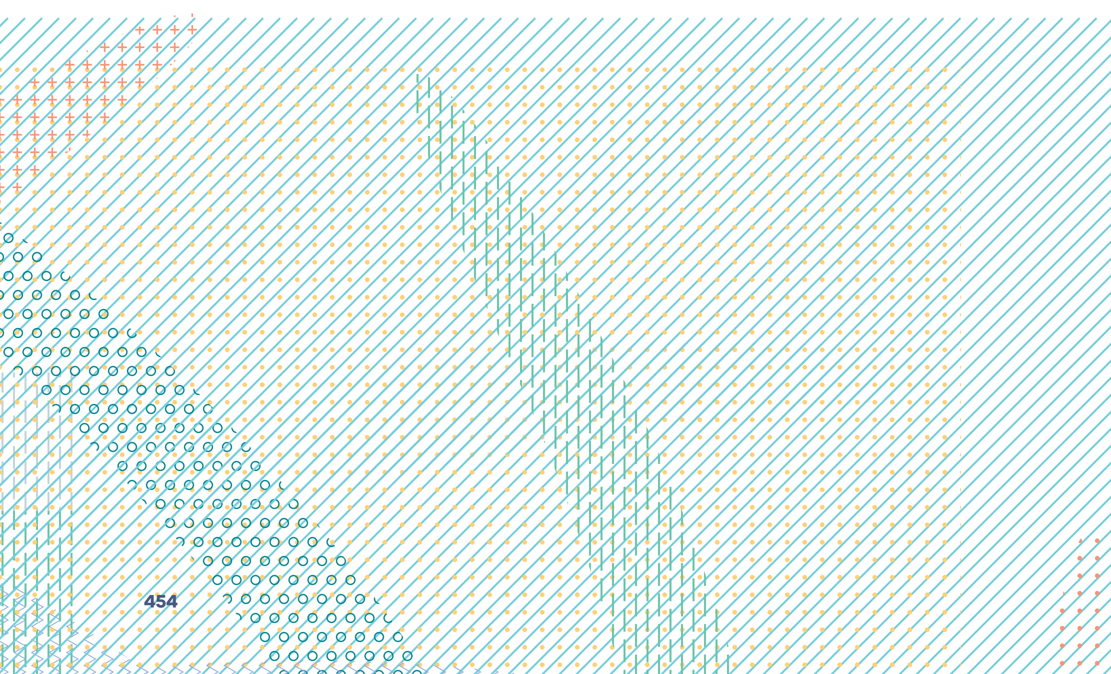
No person should feel like suicide is their only choice. Individuals, families, community groups, educational institutions and workplaces need to be better equipped and resourced to listen and respond with empathy to people experiencing suicidal behaviour. A person's desire not to live can be viewed as 'profound human suffering', and must be met with compassion and understanding.[6] Every encounter is an opportunity to intervene and, potentially, to save a life.[7]

As this chapter shows, a system-based and whole-of-government approach for suicide prevention and response is preferred, based on the varied factors that can lead to suicide. When talking about suicide prevention and response, 'system-based' means looking at all of the systems that can influence suicidality. In the words of Mr Alan Woodward, a witness and specialist in suicide prevention and mental health, these include a 'spectrum' that includes 'awareness raising, detection, early prevention, crisis intervention and recovery'.[8] This is based on the idea that no single action, service or treatment will work in isolation, requiring a concerted and continuous effort.[9]

Mental health and wellbeing services, however, have an important role to play, and access to treatment, care and support for people living with mental illness or psychological distress is an important part of this approach. Many people have attempted to receive support from the mental health system when they or a loved one experienced suicidal behaviour, only to be turned away for not being 'suicidal enough' or for 'not having a plan'.[10]

Even when people do access public specialist mental health services, the pressures on these services means they are unable to offer enough support or the right kind of services.[11] The Commission was told about the devastating consequences when people are sent home after brief stays in an emergency department or hospital, and with no follow-up care:

> My daughter suffered mental health issues and it took 12 years for someone to talk to me but by then the damage was done. She tried to take her life in the hospital and cut herself wrist to elbow. We went to the hospital and it was taped up, and she was sent home. They told us someone would call tomorrow, and no one rang. In early December she got sent into hospital to review her medication and cut her wrists in hospital with a CD. They let her out and she suicided nine days later. Now they all want to talk to me, only once she has died.[12]
>
> Currently, if someone has made an attempt on their life, they are taken to an emergency department at the closest hospital, treated, maybe seen by a mental health nurse and then sent home. There is no follow-up, assistance or treatment path provided to the patient or the carers—everyone is left on their own wondering how to deal with the situation which has just happened and terrified of when and how it may next occur and what they can do to stop it.[13]



Parents described how the system had failed their children:

> My lived experience of having a 19-year-old son who desperately was trying to live but had suffered 2.5 years of health intervention that offered him and us no effective support was too much. His suicide and the trauma of our lived experience and him telling me he just wanted to die, is something I will never get over. The health system must change![14]
>
> My story of my son's journey over 16 years—he is no longer with us, all this is too late for him, but there are still thousands out there struggling, and I would hope that I could play some little part in bringing about change. Over those years there have been so many times when I felt no-one really listened, I was not heard, despite letters to a Clinic Manager, the Complaints Commissioner, the Premier, and the Minister of Health (it was nearly a year before this letter was answered). Most of the time I felt totally alone, apart from a small support group in a neighbouring town—this group was like a lifeline to me. I suffer the grief of the loss of my son, a loved family member and a person of worth. Even worse is the grief I carry at what he suffered over 16 years, not only from a terrible illness, schizophrenia, but also in the mental health system.[15]

Within mental health settings, there is also the tragic challenge of suicides in care. In 2018–19, six consumers died by suicide while being cared for in a Victorian public mental health inpatient unit while on approved leave from the unit, following transfer from the unit to a medical ward, or within 24 hours of discharge from the unit.[16] This is discussed further in Chapter 30: *Overseeing the safety and quality of services*.

The Commission's reforms that will increase the availability and accessibility, and improve the quality and safety, of mental health and wellbeing services (described in other chapters of this report) will make a positive contribution to Victoria's suicide prevention and response efforts.

The Commission's suicide prevention and response approach supports the Victorian and Commonwealth governments' commitment to *working towards zero suicides*.[17] The approach also builds on the Commission's interim report recommendations to expand the Hospital Outreach Post-suicidal Engagement (HOPE) program, and the creation, delivery and evaluation of an assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.[18]

There is a real and urgent need to rethink the state's approach to suicide prevention and response: there has been no significant improvement in the number of people dying by suicide over the last 10 years. This is profoundly confronting and requires assertive and effective action.

Victoria must have a suicide prevention and response approach that will respond to current and future challenges. As of 30 November 2020, the Coroners Court of Victoria's data indicate that the number of suicides in 2020 is relatively consistent with the same period for 2019; sadly, 580 lives were lost in the first 10 months of 2020.[19] However, the data for presentations to Victorian emergency departments for intentional self-harm and suicidal thoughts for young people aged 0–24 years between July and September 2020, a period of sustained lockdown in response to the COVID-19 pandemic, were significantly higher than in the same period in 2019.[20] There is concern that the pandemic's negative impact on people's mental health and wellbeing will continue into the future, when unemployment and financial hardship, both risk factors for suicide, may increase.[21]

17.2 A public concern with far-reaching impacts

According to the Coroners Court of Victoria, there were 718 deaths by suicide in Victoria in 2019 (Figure 17.1).[22] Three-quarters of those who die by suicide are men.[23] In 2017, suicide was the leading cause of death among young Australians aged between five and 17 years.[24]

The rates of suicide and self-harm are even higher in rural and regional Victoria. For example, as explored in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria,* the rate of suicide among men aged 35–54 years who lived in rural and regional Victoria was about 60 per cent higher than in Melbourne.[25]

To illustrate the impact of suicide in Victoria's communities, comparisons are often made between the number of deaths by suicide each year and the annual road toll. In the past decade in Victoria, 6,320 lives have been lost to suicide, compared with 2,627 lives lost on our roads. On average, there were more than double the number of lives lost to suicide than lost on our roads each year between 2009 and 2019 (Figure 17.1). In 2019, the number of suicides was almost three times the number of road accident deaths—718 lost to suicide and 266 lost on the roads.

Despite these figures, the investment in suicide prevention and response has not been commensurate with the investment in reducing the road toll.[26] In 2016, the *Towards Zero 2016–2020 Road Safety Strategy* was announced. The goal, a worthy one, is to reduce road deaths to below 200 by 2020, and the strategy was accompanied by record investment of $1.4 billion. In the same year, the *Victorian Suicide Prevention Framework 2016–2025* was released. The goal is to halve the suicide rate by 2025. This equates to a goal of saving 326 lives.[27] A total of $27 million was invested to implement the framework—about one-fiftieth of the amount invested in the *Towards Zero Strategy*.[28]

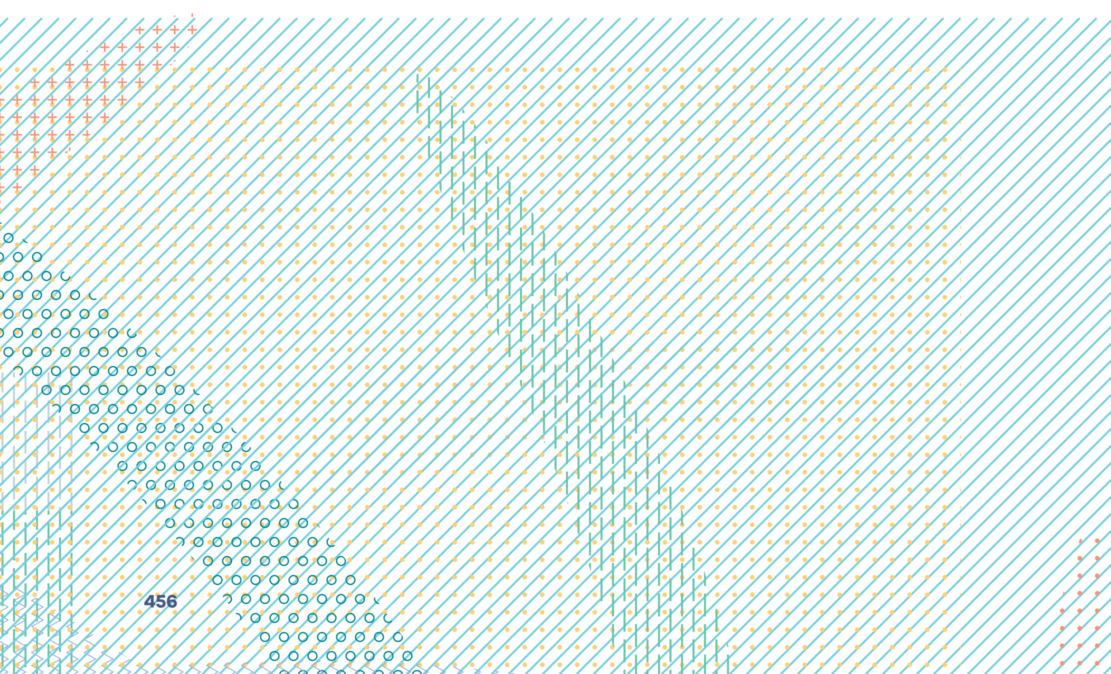
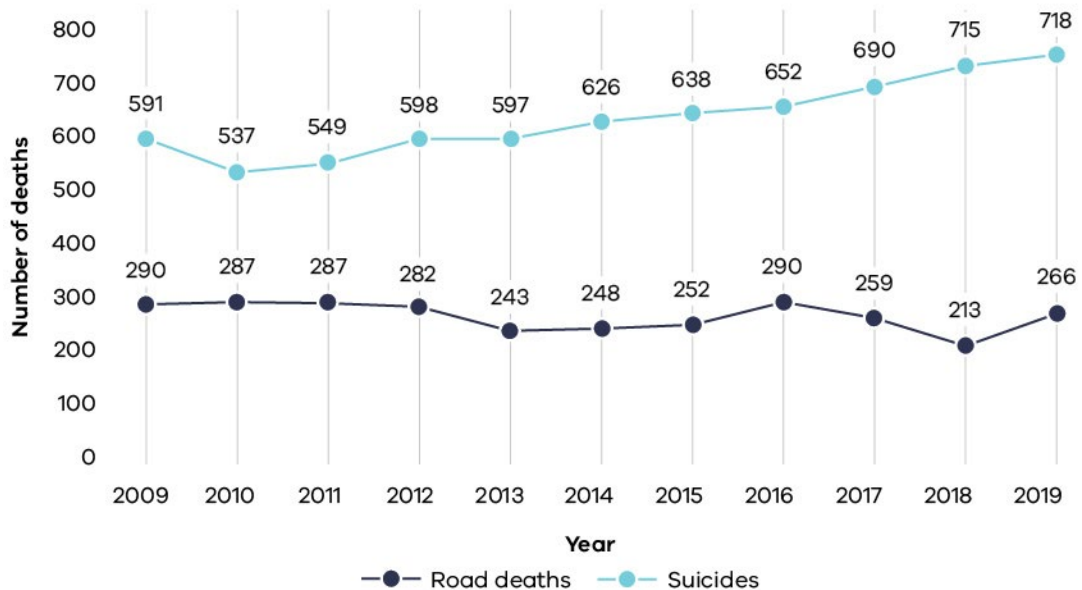


Figure 17.1: Changes in the annual number of suicides and road deaths, Victoria, 2009 to 2019



Sources: Coroners Court of Victoria, Suicide Data Summary, 2009–19; Coroners Court of Victoria, *Monthly Suicide Data Report: November 2020 Update*, 2020, p. 3; Transport Accident Commission, Search statistics, <www.tac.vic.gov.au/road-safety/statistics/online-crash-database/search-crash-data?>, [accessed 20 September 2019].

The Commission uses the term 'suicidal behaviour' to represent both those who are experiencing suicidal thoughts and those who are experiencing suicidal behaviour, such as suicide attempts or self-harm. The rates of suicidal behaviour are significantly higher than the number of deaths by suicide. In 2018 in Victoria, the number of people who were reported to have been hospitalised for self-harm was more than 10 times the number of those who died by suicide.[29] The *2007 Australian Bureau of Statistics National Survey of Mental Health and Wellbeing* found that more than 30 times as many people try to end their life each year as die by suicide.[30]

An analysis of survey data found that:

- 13.3 per cent of Australians aged 16–85 years reported experiencing suicidal thoughts at some point in their life
- 4.0 per cent reported that they had made suicide plans
- 3.3 per cent reported having attempted suicide.[31]

When someone dies by suicide, the people affected most are those closest to them—family members, friends, co-workers, classmates and intimate social contacts. Up to 135 people can be exposed to each suicide death.[32] On this basis, approximately 97,000 Victorians were affected by the suicide of a loved one, friend, colleague or associate in 2019 alone.

17.2.1 Little improvement in the suicide rate

Despite a strong focus on suicide prevention in recent Commonwealth and state government mental health plans, data indicate that there has been no meaningful improvement in Victoria's suicide rate over the past 10 years.[33]

One measure for reporting on suicide is the standardised death rate, which is the number of suicide deaths per 100,000 population. This rate enables meaningful comparisons to be made as populations change in size over time.[34]

Australian Bureau of Statistics data show that in 2018, in Australia, the national average was 12.1 deaths by suicide per 100,000.[35] Victoria had the lowest standardised death rate for suicide in any Australian state or territory, at 9.1 deaths per 100,000 people.[36] This rate has remained relatively stable between 2009 and 2018, with some minor fluctuations.[37]

While these data indicate that Victoria is performing better than some other states and territories, the fact that Victoria has been unable to significantly reduce its suicide rate shows that more needs to be done.

Mr Woodward told the Commission of several reasons why Victoria has been unable to reduce its suicide rate:

- There is inadequate coordination of effort and insufficient resources, as well as a lack of universal coverage for a range of important services such as aftercare programs, workforce training, supports for people in suicidal crisis, school-based prevention programs and bereavement supports.[38]
- There is a need to ensure suicide prevention funding is provided to a broad range of services—including mental health services, housing, youth justice, family support, education and community and social services—to create a whole-of-government approach to suicide prevention.[39]
- There is insufficient coordination between programs and services at the Commonwealth and state levels, leading to duplication and service gaps.[40]

17.3 Suicide risk and protective factors

Suicide prevention and response approaches need to account for the fact that suicide is a multifaceted problem, and suicide rates are the product of a complex mix of 'systemic, societal, community, relationship and individual' factors.[41]

A history of self-harm is a primary risk factor associated with suicide.[42] The majority of people who die by suicide have a history of self-harm, and self-harm can be viewed as a precursor to potentially lethal suicidal behaviour, particularly in adolescents.[43]

A recent study reported that people living with and without mental illness who died by suicide had multiple immediate stressors recorded as present at the time of their death. This research grouped these stressors into the following categories:[44]

- personal—for example, sexuality, isolation and experience of abuse
- interpersonal—for example, conflicts with a partner, family members and non-family members
- physical—for example, illness, injury and pain
- situational—for example, work, financial, legal, education, bullying and substance-related
- exposure to suicide—for example, of a family member.[45]

Professor Jane Pirkis, Director of the Centre for Mental Health in the Melbourne School of Population and Global Health at the University of Melbourne, also highlighted some sociodemographic characteristics as risk factors, citing, for example, that males are at a greater risk of suicide than females.[46]

Several stressors often occur simultaneously.[47] Overall, mental illness or psychological distress, alcohol or other drug use, physical illness, divorce or relationship separation, and trouble with the police, are the most commonly reported stressors.[48] Suicide is also partly influenced by the attitudes and actions of others.[49]

Ms Harman emphasised that life stressors can be the 'tipping factors' that can contribute to suicidal behaviour and suicide attempts:

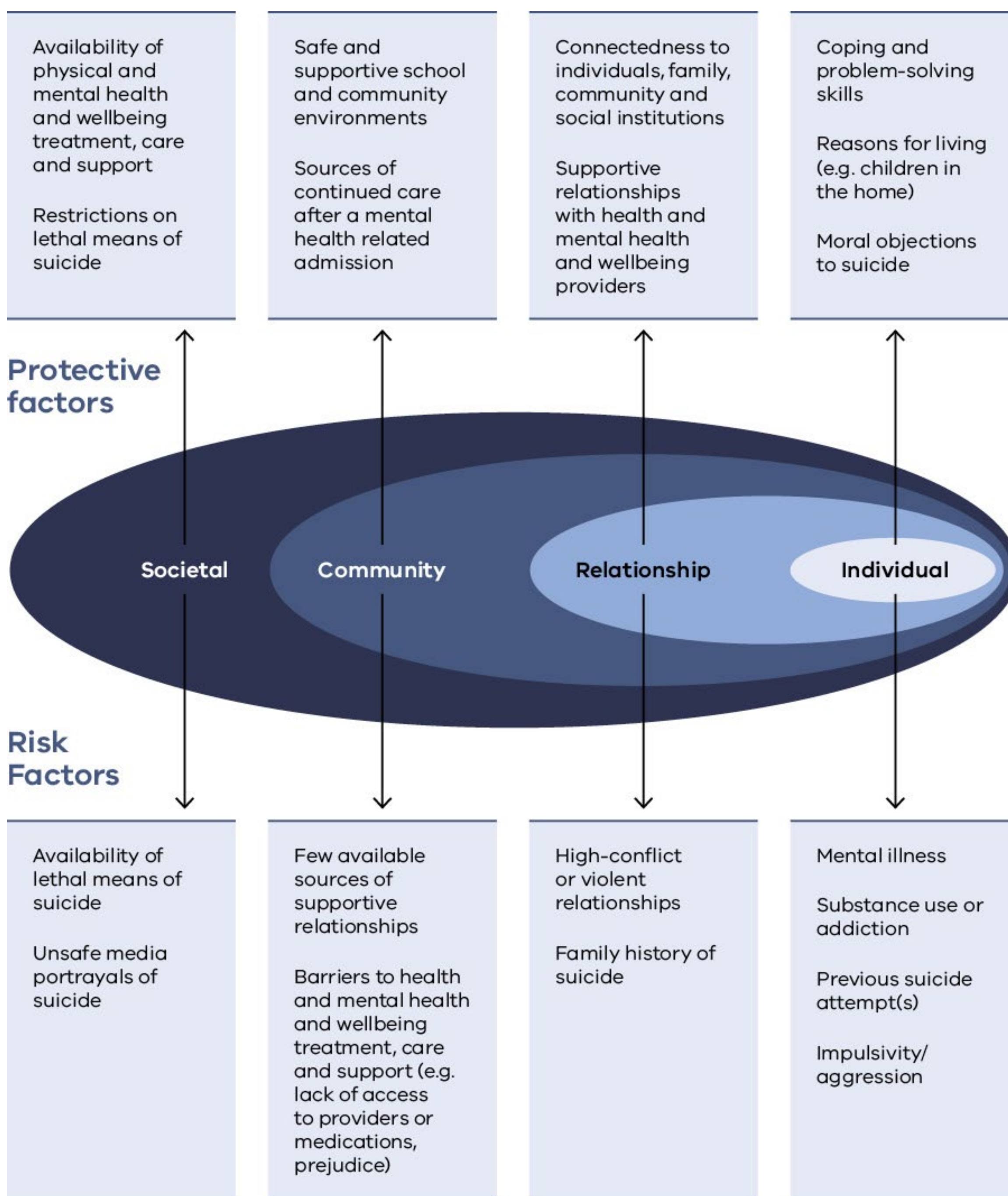
> **of people who think about suicide or attempt suicide, or indeed die by suicide, many do live with mental health conditions; but some don't, and it can be those tipping factors in life that actually cause suicidal distress ... homelessness, losing your job, living in extreme poverty, or you're just not able to put food on the table or pay the rent, relationship breakdowns, these are the life stressors that can massively contribute to suicidal behaviour and suicide attempts.**[50]

There are also protective factors that make it less likely for an individual to consider, attempt or die by suicide.[51] Protective factors include:

- availability of physical and mental health and wellbeing treatment, care and support
- safe and supportive school and community environments
- connectedness to family, community and social institutions.[52]

Figure 17.2 shows some of the major risk and protective factors relating to suicide.

Figure 17.2: Risk and protective factors for suicide



Source: Adapted from US Office of the Surgeon General. US National Action Alliance for Suicide Prevention 2012. <www.ncbi.nlm.nih.gov/books/NBK109906/>, [accessed 27 October 2017].

Some people perceive suicide as a rational response to extreme distress; and some people may consider that Victoria's voluntary assisted dying legislation contradicts the Victorian Government's aim to prevent suicide. This legislation has strict rules, though, and people can only access the voluntary assisted dying scheme in very limited circumstances. Making a decision to end one's life results from many different factors and the whole community needs to work to address these factors.

17.3.1 Mental illness and suicide

While mental illness can be a risk factor for suicide, people without a diagnosed mental illness also die by suicide. Mental illness can be a factor in suicidal behaviour, but it is not the only factor, and it might not even be the primary factor.[53]

Caution is needed in attributing any causal link between mental illness and suicide.[54]

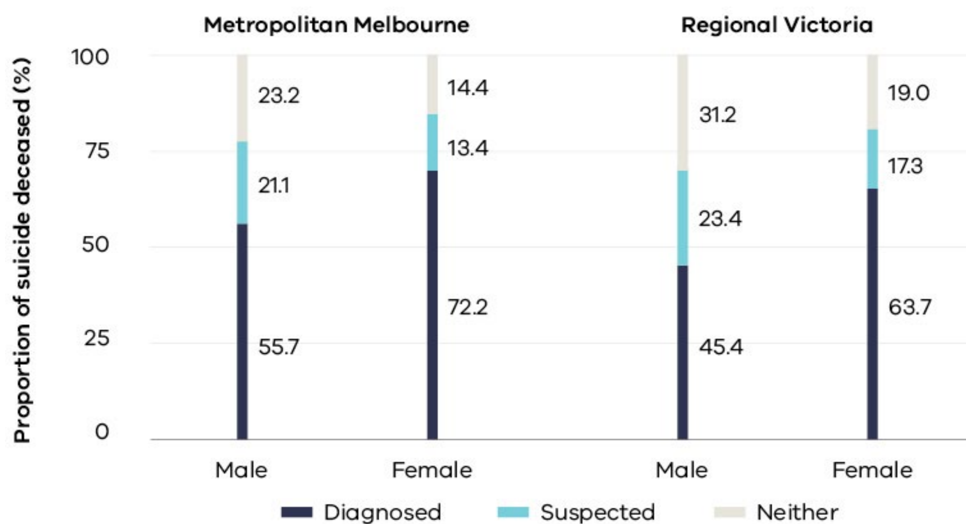
Professor Pirkis explained the link:

> Suicidal behaviour is related to but also distinct from mental illness. Mental illness heightens the risk of dying by suicide, but there are a range of other factors that increase the risk of suicide, including immediate/proximal stressors that may be present both for those who have a mental illness and those who do not.[55]

Information about Victorians who die by suicide is held in the Victorian Suicide Register. Among the information recorded is the person's gender, their usual place of residence, and whether they had a diagnosed mental illness, a suspected mental illness or neither. The data are used to inform suicide prevention strategies and recommendations made by the Coroner.

Victorian Suicide Register data showed that between 2009 and 2016, approximately 57 per cent of Victorians who died by suicide had a diagnosed mental illness, and approximately 20 per cent had a suspected mental illness.[56] A higher proportion of females compared with males had a diagnosed mental illness, and a slightly higher proportion of males compared with females had a suspected mental illness or no mental illness.[57] A higher proportion of metropolitan Melbourne residents (both male and female) had a diagnosed mental illness compared with regional Victorians (refer to Figure 17.3).

Figure 17.3: Diagnosed and suspected mental illness among suicide deceased, Victoria, 2009 to 2016



Source: Coroners Court of Victoria, Data update prepared for the Royal Commission into Victoria's Mental Health System, 2009 to 2016.

17.4 Commonwealth and state suicide prevention and response efforts

Both the Commonwealth and Victorian governments have committed to system-based and whole-of-government suicide prevention and response efforts, through the *Fifth National Mental Health and Suicide Prevention Plan* in August 2017.[58] One of the actions from the plan was the development of the *National Suicide Prevention Strategy*, which Ms Kym Peake, then Secretary of the former Department of Health and Human Services, described as a reaffirmation of 'each government's commitment to implement a systems-based approach to suicide prevention'.[59]

At the national level, there has been a promising and elevated focus on suicide prevention and response efforts, including the appointment of Ms Christine Morgan as the National Suicide Prevention Adviser to the Prime Minister in July 2019. Ms Morgan's duties include advising the Prime Minister on the effectiveness of the design, coordination and delivery of suicide prevention and response activities, and developing ways to improve whole-of-government responses.[60] The Commonwealth Government released Ms Morgan's initial advice, developed by the National Suicide Prevention Taskforce, in January 2020 and the interim advice in November 2020. Ms Morgan's final advice was due to be submitted to the Commonwealth in December 2020.

The Productivity Commission's *Mental Health Inquiry Report* also considered suicide prevention and response, with a focus on how roles and responsibilities were divided among the Commonwealth, and state and territory governments.[61] Both Ms Morgan and the Productivity Commission have found there is a lack of clarity about the types of suicide prevention and response activities that different tiers of government should initiate, leading to duplication and gaps in service delivery.[62] In her evidence to the Commission, Ms Morgan, in her capacity as the CEO of the National Mental Health Commission, said:

> While Australia has seen significant funding and activity in suicide prevention, there persists some lack of clarity about what types of suicide prevention activities should be the responsibility of the various levels of government and the sector more broadly. As a result, all levels of government, and indeed the private sector, fund a wide range of suicide prevention activities, raising the potential for duplicative efforts.[63]

The National Suicide Prevention Taskforce's interim advice outlines 13 'in-principle' recommendations, including a shift to whole-of-government leadership and governance; a standalone national suicide prevention strategy; a suicide prevention workforce plan; recognition that lived experience knowledge is central to the planning and delivery of the national strategy; and improved data and evidence to inform decision making.[64]

There is substantial alignment between the Commission's recommendations and the taskforce's in-principle advice, particularly in regard to:

- a shift to a whole-of-government approach, including national whole-of-government governance structures and a new national suicide prevention strategy[65]
- all governments and their agencies ensuring that people with lived experience of suicide or bereavement by suicide are central to planning, priority setting, design and delivery of suicide prevention and response activities[66]
- a long-term whole-of-government workforce strategy, including contemporary and evidence-informed training for clinical, other health staff and 'frontline' workers[67]
- more effective and earlier responses to people experiencing distress, including scoping options for a Distress Brief Intervention program (discussed later in this chapter) in Australia.[68]

At the time of finalising its report, the Commission did not have access to the Commonwealth's response to either the taskforce's initial advice or to the Productivity Commission's *Mental Health Inquiry Report*, nor Ms Morgan's final report. Despite this, and as discussed further throughout this chapter, there is clear alignment between the advice to the Commonwealth and the Commission's recommended suicide prevention and response approach. The Commission strongly believes there is an opportunity for the Victorian Government to work with the Commonwealth in implementing the Commission's recommendations, with the new suicide prevention and response strategy for Victoria to complement the Commonwealth's efforts. It is imperative that both governments work collaboratively to ensure state and Commonwealth suicide prevention and response initiatives are complementary and coordinated.

Looking ahead, there is also an opportunity for a structured, coordinated approach to planning and investment through the new *National Mental Health and Suicide Prevention Agreement*, including a commitment to increased, long-term investment and enduring reform efforts in suicide prevention and response services. As set out in Chapter 29: *Encouraging partnerships,* the Commission advocates for this work to have a strong focus on implementation through detailed, staged implementation plans in which responsibilities, timelines, costs and evaluation points are clearly laid out.

17.4.1 Suicide prevention and response initiatives in Victoria

Victoria has implemented several suicide prevention and response initiatives, with the two main initiatives sitting under the state's current *Suicide Prevention Framework 2016–2025*. These are:

- Place-based suicide prevention trials in collaboration with Primary Health Networks: there are 12 trial sites across Victoria, which deliver suicide prevention activities consistent with the LifeSpan model (Figure 17.5) of building the capacity of local communities, raising awareness, responsible media training, other targeted training and health and wellbeing events.[69] In the 2016–17 State Budget, the Victorian Government funded six sites over four years to 2019–20,[70] with an extension announced in 2020 to June 2022.[71] The then Department of Health and Human Services determined how the sites ran, and required them to focus on building the capacity and effectiveness of local services, rather than expanding services or creating new ones[72]
- The HOPE program: this program is designed to support people after they are discharged from hospital following a suicide attempt. It also supports people who express suicidal thoughts or repeatedly intentionally self-harm but who do not meet the threshold for entry to specialist mental health services.[73] HOPE teams support individuals and their support networks for up to three months after discharge, assisting them to identify and build protective factors against suicide.[74]

As stated earlier in this chapter, the Commission's recommended approach supports working *towards zero suicides*. Its interim report made two recommendations to help achieve this aim:

- Expand the HOPE program by funding all area mental health services to offer HOPE on a regular basis. Measures to support this are broadened referral pathways from community-based mental health teams—that is, more ways in which people can access the program—as well as additional clinical outreach services in each subregional health service, and extended service delivery hours.[75]
- Create, deliver, then evaluate the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.[76]

The Victorian Government is currently implementing these recommendations.

17.5 The Royal Commission's recommended governance approach to suicide prevention and response

As discussed earlier in this chapter, suicidal behaviour can occur for a range of reasons, requiring a whole-of-government focus[77] that extends beyond a single health response. In the context of suicide prevention and response in Victoria, 'whole-of-government' refers to areas such as Aboriginal affairs, education, environment, health, industry, justice, planning, transport, social services and sport, as well as Commonwealth, state and local government.

The National Suicide Prevention Taskforce's initial advice to the Prime Minister stated that whole-of-government efforts are 'vital' to moving towards a more substantive suicide prevention and response approach, reporting that 'through the breadth of government and other services, we can address the social and economic drivers of distress and reach out to people as early as possible, building social connection, support and hope'.[78] The Productivity Commission's *Mental Health Inquiry Report* also recognised the importance of whole-of-government efforts and recommended that Commonwealth, state and territory governments identify responsibilities for suicide prevention and response activities across portfolios 'to create a truly whole-of-government approach to suicide prevention'.[79]

Data also support the understanding that suicide can occur due to personal stressors. For example, Victorian Suicide Register data showed that between 2009 and 2015, for those aged between 35–74 years who died by suicide, in 58.9 per cent of incidents there was evidence of a 'partner' stressor, such as a partner death, separation, conflict, health issues or family violence.[80]

The Department of Health has primary responsibility for suicide prevention and response, but other departments deliver various related programs. For example, the Department of Transport works to restrict means of suicide, such as restricting access to train platforms and fencing at known hotspots.[81] The main body governing suicide prevention and response is an interdepartmental committee that coordinates suicide prevention and response activities across government.[82] It is chaired by the Department of Health and the members are directors of relevant workstreams.[83]

In considering Victoria's approach to suicide prevention and response, Suicide Prevention Australia submitted to the Commission that:

> **Whilst health and mental health are components of suicide prevention, a more holistic, whole-of-government approach is required when considering how best to positively impact suicide rates in Victoria. Better cross-portfolio coordination is essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention.[84]**

Ms Peake told the Commission that substantial changes in the governance and prominence of suicide prevention and response is needed, with high-profile leadership.[85]

In contrast, other states, such as New South Wales and Queensland, have whole-of-government structures for preventing and responding to suicide.[86] These states' suicide prevention and response strategies are supported by senior membership and leadership, and the strategies specify that there should be government roles that cross departments, enabling those departments to work better together.

The Commission observes that in these states, as well as South Australia, suicide prevention and response has been championed at the highest levels of government. Suicide prevention and response has been listed as a 'premier priority' in both New South Wales and Queensland, while South Australia has established the South Australian Premier's Council on Suicide Prevention. Ms Harman pointed to South Australia as an effective example of bringing interested people together across ministerial portfolios to work together and elevate the profile of suicide prevention and response.[87] The high-profile commitment by these governments to reduce the suicide rate has enabled a range of agencies to be accountable for achieving this ambition and contributing to a whole-of-government approach.

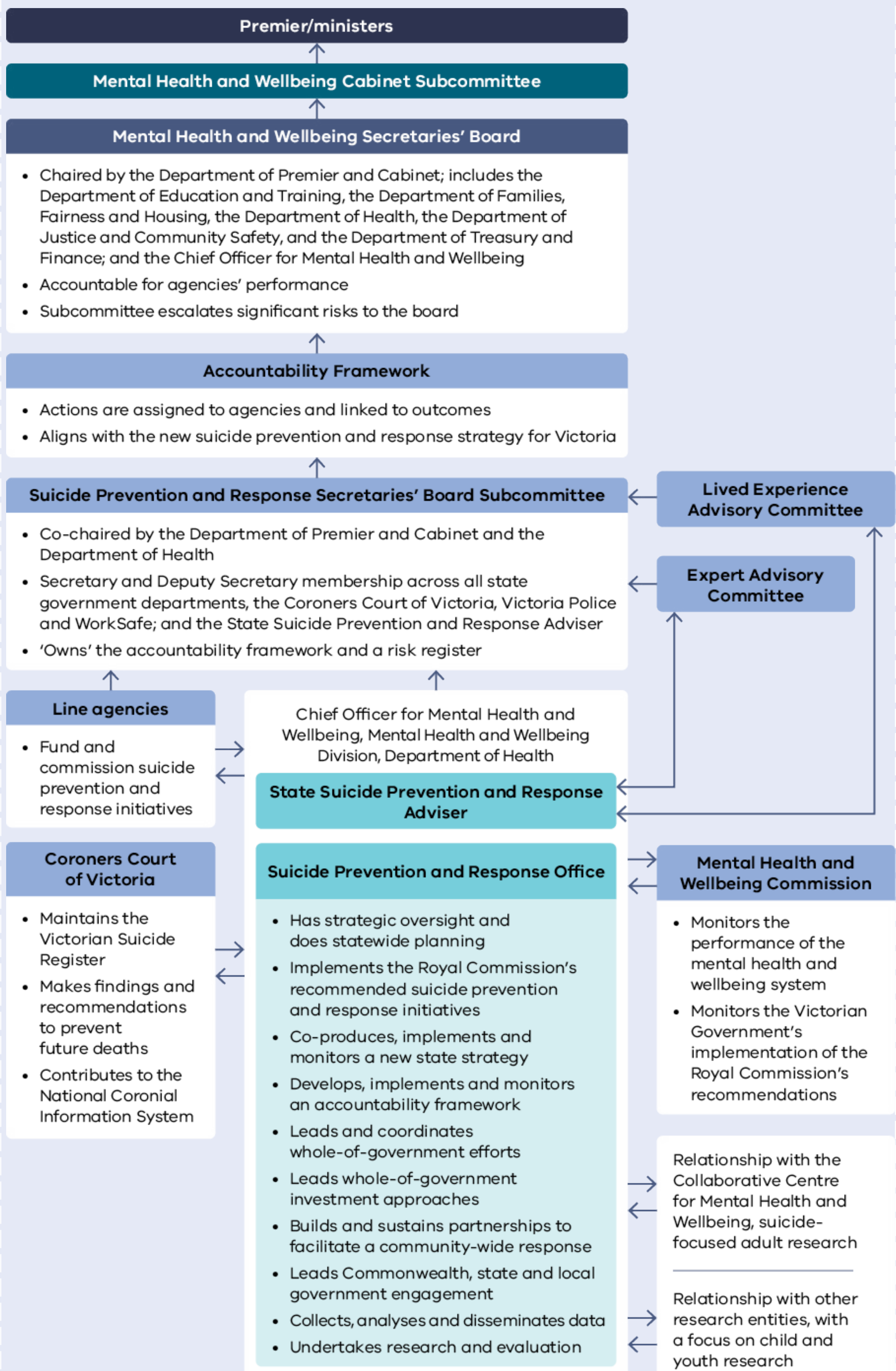
To strengthen Victoria's suicide prevention and response efforts, and to raise the profile of suicide prevention and response in government decision making, the Commission recommends establishing a new Suicide Prevention and Response Office. This will involve the employment of, and interaction with, people with lived experience of suicidal behaviour and bereavement by suicide.

As shown in Figure 17.4, whole-of-government governance arrangements will be facilitated through a Suicide Prevention and Response Secretaries' Board Subcommittee. The subcommittee is co-chaired by the Department of Premier and Cabinet and the Department of Health, and comprises Secretary and Deputy Secretary membership, representing all state government departments, the Coroners Court of Victoria, Victoria Police and WorkSafe. The subcommittee will be attended and supported by the State Suicide Prevention and Response Adviser. The subcommittee is responsible for promoting actions across government, in line with the new suicide prevention and response strategy for Victoria and the Commission's relevant recommendations. The subcommittee reports to the Mental Health and Wellbeing Secretaries' Board, which is responsible for overseeing implementation of all the Commission's reforms. The Secretaries' Board is discussed in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*.

The Suicide Prevention and Response Office will be well resourced and will be headed by a State Suicide Prevention and Response Adviser reporting to the Chief Officer for Mental Health and Wellbeing, who leads the Mental Health and Wellbeing Division within the Department of Health (refer to Figure 17.4).

Strong leadership will be critical to keeping suicide prevention and response on the government's and community's agenda helping Victoria on its path *towards zero suicides*. The State Suicide Prevention and Response Adviser must have experience in leading implementation and reform work, change management and working across government portfolios. They must also have strong communication skills and experience working with interested parties.

Figure 17.4: Recommended structure of the Suicide Prevention and Response Office



The Commission recommends that the new office has a core set of functions that will enable it to lead and coordinate whole-of-government efforts, drive systemic and evidence-informed reform, and help it engage with the community. The office will also be responsible for implementing the Commission's recommended suicide prevention and response initiatives, including the interim report's relevant recommendations.

While the office leads and coordinates whole-of-government efforts, it must also work closely with other parts of the Department of Health, to maintain important links with the mental health and wellbeing and health portfolios, and with implementation of the Commission's other recommendations. The office will also be required to work closely with the Regional Mental Health and Wellbeing Boards in the commissioning of new services, which are recommended in Chapter 5: *A responsive and integrated system*.

The office must be adept in developing and sustaining partnerships across government so it can lead and coordinate whole-of-government efforts. In particular, it will work closely with the Coroners Court of Victoria, which plays a vital role in suicide prevention and response. While Victorian coroners have a legislated role to establish the circumstances of a death,[88] they also focus on identifying system-wide issues to prevent similar deaths in the future, including making recommendations to relevant public entities such as government agencies or health services.[89]

The Coroners Court established and maintains the Victorian Suicide Register, which supports coroners in making evidence-informed recommendations to reduce suicides, and helps government and community organisations develop policy, research and initiatives.[90] The Coroners Court also contributes to the National Coronial Information System—a national database, extending to New Zealand, that contains information on reportable deaths, helping to 'inform research and prevention efforts at a national scale'.[91]

A collaborative partnership between the Suicide Prevention and Response Office and the Coroners Court of Victoria will enable improvement of suicide prevention and response efforts. It will take advantage of the expertise and insights both bodies have, with the potential to better implement coroners' recommendations, at both the individual and system levels.

As discussed earlier, a productive working relationship with the Commonwealth Government will be essential in ensuring Victoria's approach to suicide prevention and response coordinates with, and complements, the Commonwealth Government's efforts. This is particularly relevant given the recent focus on suicide prevention and response at the national level, with the appointment of the National Suicide Prevention Adviser and the Productivity Commission's *Mental Health Inquiry Report*.

17.5.1 A new, co-produced suicide prevention and response strategy for Victoria

The Commission recommends that from its inception the Suicide Prevention and Response Office works closely with people who have lived experience of suicidal behaviour or bereavement by suicide, to co-produce a new suicide prevention and response strategy for Victoria, in line with the parameters outlined in Table 17.1.

The Commission understands that in the design and delivery of suicide prevention and response initiatives in Victoria, for the most part, there have been minimal formal procedures for interacting with people with lived experience of suicidal behaviour or bereavement by suicide. The knowledge and expertise of people with lived experience is vital to creating high-quality services, including lived experience–led initiatives, programs and policies. It is particularly important in understanding what interventions would make the most difference to people experiencing suicidal behaviour.

As a mother bereaved by the suicide of her son shared with the Commission:

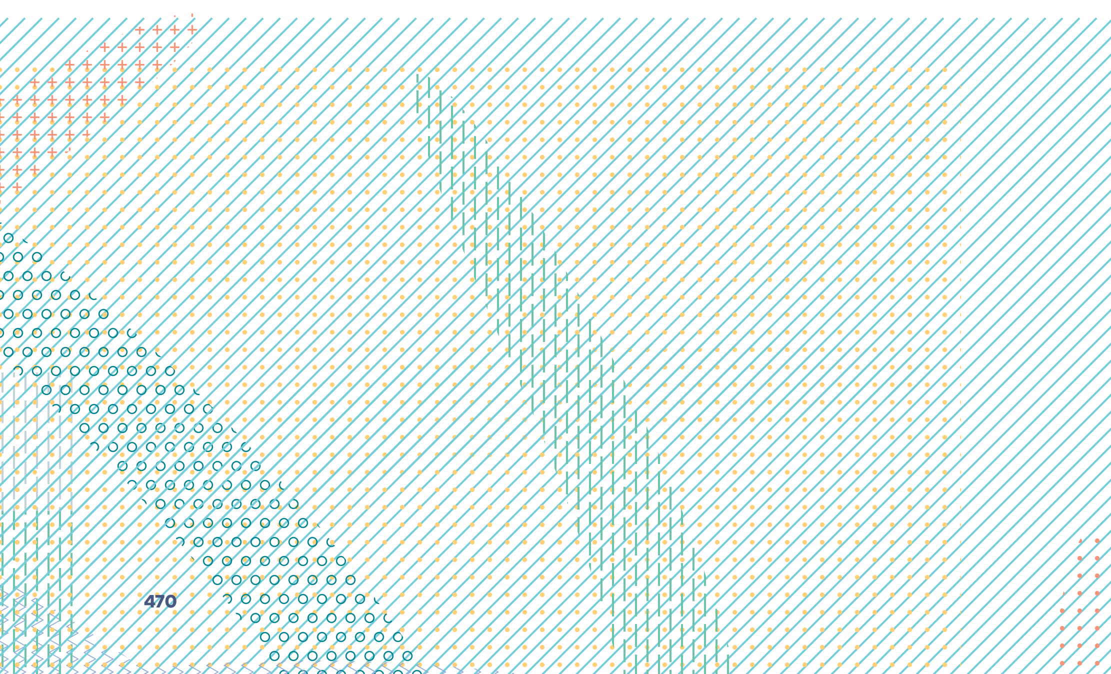
> I have lived experience in losing my 19-year-old son four years ago. I've found that with my experience … comes a certain knowledge and understanding that I think it's important to share, and important to learn from other people in this space as well, so that we can help prevent it, and help other people avoid going through what we've been through as lived experience.[92]

Victoria's current strategy, the *Victorian Suicide Prevention Framework 2016–2025*, has been important in helping to implement the HOPE program and the place-based suicide prevention and response trials described earlier. It has been criticised, however, as being too health-focused.

Suicide Prevention Australia told the Commission that the current strategy does not deal with the wider risk factors that can lead to suicidality, and that there is no overarching framework where suicide prevention and response initiatives come together to reduce suicidality.[93] The framework is also over four years old, meaning it is already dated. In particular, it cannot take advantage of recent research into the benefits of whole-of-government approaches, as the more contemporary suicide prevention and response strategies in New South Wales and Queensland do.[94] Updating the strategy will also provide an opportunity to complement and account for the Commonwealth's direction to suicide prevention and response, such as the National Suicide Prevention Taskforce's in-principle recommendations.

Table 17.1: Parameters of the recommended suicide prevention and response strategy for Victoria

Parameter	Description
Co-production	Co-produce the strategy with people with lived experience of suicidal behaviour and people with lived experience of bereavement by suicide.
Objective	Establish an overarching objective that stakeholders collectively work towards such as 'towards zero suicides'.
Evidence-informed	Develop the strategy on evidence-informed approaches to suicide prevention and response, and adopt a whole-of-government, community-wide and system-based approach.
Education	Develop, implement and monitor public education campaigns and partnerships across multiple portfolios.
Initiatives	Start with the Royal Commission's recommended suite of suicide prevention and response initiatives.
Accountability	Develop a public implementation plan that goes along with the new strategy. This will assign actions to agencies, link actions to outcomes and form the basis of an accountability framework that evolves over time to reflect advances in data collection, linkage and analysis. The Suicide Prevention and Response Secretaries' Board Subcommittee will oversee the implementation plan and accountability framework. The new Mental Health and Wellbeing Commission, responsible for monitoring the implementation of all the Royal Commission's recommendations, will likewise have a role in monitoring the progress of the implementation of the Commission's recommended suicide prevention and response initiatives.
Adaptability	Be adaptable and responsive to new evidence and Commonwealth direction. The strategy will cover a 10-year period to provide certainty and direction but include phased implementation in two- to three-year instalments, allowing for adjustments to reflect new evidence and lessons learnt from evaluations.
Targeted cohorts	Consider where initiatives should be tailored or designed to the needs and interests of particular cohorts that may be at higher risk of suicidal behaviour and suicide.



17.5.2 A comprehensive, system-based approach to suicide prevention and response initiatives

While the evidence base for suicide prevention and response is emerging, many contemporary approaches look to the World Health Organization's 2014 report, *Preventing Suicide: A Global Imperative*. The report emphasises the need for a system-based approach to suicide prevention and response, and the importance of coordination and collaboration across multiple sectors of society, both health and non-health sectors, and public and private sectors, noting that '[t]hese efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide.'[95]

Across the Commission's work, it has adopted a system-design approach to its reforms. In Chapter 1: *The reform landscape,* the Commission has identified five features—prioritisation, collaboration, adaptability, simplicity and equity—to collectively strengthen the mental health and wellbeing system. For suicide prevention and response, a system-based approach has also been used to guide the Commission's recommended approach.

As established in the interim report, the Commission understands that one of the best examples of a system-based approach to suicide prevention and response in Australia is LifeSpan (Figure 17.5).[96] This model was developed by the Black Dog Institute, an Australian research institute focused on mental health and wellbeing, and consists of nine evidence-informed strategies that are directed at either the population or individual level.[97] Since the LifeSpan model was developed in 2016, research has advanced in the area of postvention support services (services provided to those who have been bereaved by suicide), and step two should now be considered as psychosocial (or wellbeing) supports and/or pharmacotherapy.

Researchers have estimated that using a system-based approach could potentially lead to a 'significant reduction in suicide attempts and suicide deaths in Australia', and a combination of interventions could prevent approximately 28 per cent of suicide attempts and up to 21 per cent of suicide deaths.[98]

In Victoria, the two flagship suicide prevention and response initiatives discussed earlier, the HOPE program and the place-based trials, represent both ends of the service continuum, with the HOPE program supporting those who have attempted suicide and the trials focusing on prevention.

Figure 17.5: The LifeSpan model

Source: R Ridani and others, *An evidence-based systems approach to suicide prevention guidance on planning commissioning and monitoring*, Sydney: Black Dog Institute, 2016.

The Commission considers it imperative that Victoria's suicide prevention and response efforts are expanded to create a more comprehensive and system-based approach. The Commission has recommended a suite of suicide prevention and response initiatives (Table 17.2) based on the Black Dog Institute's LifeSpan model (Figure 17.5).

As New South Wales and Queensland have developed respective suicide prevention and response state strategies that comprise whole-of-government and system-based approaches, the Suicide Prevention and Response Office should seek to consult these states to learn from their relevant research, evaluations and implementation approaches.

17.5.3 Recommended suicide prevention and response initiatives

To move Victoria towards a system-based approach to suicide prevention and response, the following sections outline a suite of recommended initiatives. These initiatives have been discussed in order of priority.

The Commission has used the following criteria to order these initiatives:

- the initiative's alignment with the preferences of people with lived experience of suicidal behaviour or bereavement by suicide
- the evidence base for the initiative
- the ability to scale the initiative statewide without any loss of quality
- opportunities for aligning with and complementing Commonwealth Government initiatives
- the initiative's ability to reduce gaps between Victoria's current approach to suicide prevention and response and evidence-informed practice.

The Commission recommends that the first four initiatives (refer to the first column in Table 17.2) are implemented as a matter of priority by the Suicide Prevention and Response Office, with the remaining four (listed in the second column) to be included in the new suicide prevention and response strategy for Victoria and funded over time. Further initiatives (in the third column) are recommended in separate chapters, such as improved and expanded responses to people experiencing mental health crises in Chapter 9: *Crisis and emergency responses*.

Youth suicide and suicidal behaviour is the focus of Chapter 13: *Supporting the mental health and wellbeing of young people*, which recommends substantial reform and investment in services for young people. This is in addition to the interim report's recommendation to establish an aftercare service for children and young people who have self-harmed or who are at risk of suicide.[99]

Table 17.2: Recommended suicide prevention and response initiatives

Priority initiatives to be implemented by the Suicide Prevention and Response Office	Initiatives to be included in the new suicide prevention and response strategy for Victoria and funded over time	Suicide prevention and response initiatives that are outlined in separate chapters
Major statewide investment across Victoria's workforces, communities and workplaces to better support people experiencing suicidal behaviour	Working towards eliminating the suicides of Victorians being cared for in health services	Improved responses to people experiencing mental health and suicidal crises, including 24-hour, seven-day-a-week crisis responses; improved emergency department responses; 'safe spaces' for young people and adults; and alternatives to police responses (Chapter 9: *Crisis and emergency responses*)
An aftercare service following a suicide attempt specific to LGBTIQ+ Victorians, to be co-produced and implemented with LGBTIQ+ Victorians	Suicide prevention local alert systems that bring local stakeholders together and use real-time data to trigger a service response	Improved ways to find and access treatment, care and support, including a comprehensive website and online self-help resources (Chapter 8: *Finding and accessing treatment, care and support*)
Statewide postvention bereavement support		
A program for people experiencing psychological distress, with wide referral pathways into the program	Supporting communities to implement localised suicide prevention activities through a grants program	Support for families, carers and supporters, including a website with information for people who are caring for someone who is experiencing suicidal behaviour (Chapter 19: *Valuing and supporting families, carers and supporters*)
	Further strengthening aftercare following a suicide attempt by extending the referral pathways into HOPE	Investment in residential peer-led recovery respite services for people who are experiencing a mental health crisis or suicidal behaviour (Chapter 10: *Adult bed-based services and alternatives*)

(Universal) Target group: The whole population

(Selective) Target group: At-risk individuals or groups at greater risk of suicidal behaviour

(Indicated) Target group: Individuals experiencing suicidal behaviour

17.6 Recommended suicide prevention and response initiatives for immediate implementation

The Commission recommends that the following suicide prevention and response initiatives be implemented by the Suicide Prevention and Response Office as a priority.

17.6.1 Statewide investment across Victoria's workforces, communities and workplaces

The Commission recommends that the Suicide Prevention and Response Office develops a statewide training program across Victoria's workforces, communities and workplaces, to support people experiencing suicidal behaviour, and coordinates the program's implementation.

The recommendation aims to:

- improve the identification of people experiencing suicidal behaviour
- increase early intervention
- improve compassionate responses
- reduce stigma associated with suicidal behaviour
- empower members of the community to openly and safely discuss suicidal behaviour
- align with whole-of-government efforts by including all workforces that are likely to interact with people at risk of suicide.

The recommendation consists of three components outlined below. The office will collect and maintain data on the number of people who complete each component, meaning that for the first time, Victoria will have oversight of how many people have accessed these important resources, and if they are reaching Victoria's diverse communities and rural and regional areas.

(i) Component 1: Standardised workforce training

Many contributions to the Commission have highlighted the importance of people receiving compassionate responses when they are experiencing suicidal behaviour, and the negative impact a lack of such a response can have.

In a submission to the Commission, prepared by Victoria Legal Aid, a consumer highlighted the lack of compassion received when seeking help at an emergency department:

> When I got there, I had the world's worst triage nurse. She was just the rudest, most awful person. Not very smart either. When I spoke about my suicidality, she decided—without any context or discussion with me—that my suicidality was just attention seeking brought on by watching 13 Reasons Why. It was such a stupid thing to say. She didn't know how real this was for me. This was the first time I had spoken openly about this—I had made myself vulnerable. I had hidden it for so long.[100]

Ms Rachel Bateman, a witness, told the Commission:

> I don't think I have all the answers for how to reduce suicide rates, but I know that, at the very least, services should meet people with empathy and a genuine desire to understand what's going on for them. In my personal experience, when I seek support from [emergency departments], I am not always met with empathy.[101]

Similarly, Mr Woodward emphasised that:

> The pivotal point for all services and responses to suicide … is the importance of compassion and respectful, non-judgemental support for those individuals who become suicidal for whatever reasons in their lives, and for those who care for them and are impacted by the trauma of a suicidal event or death.[102]

Research suggests that a compassionate approach is the most useful way to interact with people experiencing suicidal behaviour and that this approach can encourage disclosure of the concerns and behaviours people are experiencing.[103]

Teresa, a witness, shared with the Commission the importance of being responded to with empathy:

> My experience in hospital worked out to be a very positive one. Almost every step of the way, I felt that people listened to me, understood me and were able to direct me to the help I needed. It was the first time that I have ever felt this way about the mental health system. Compared to the previous times that I had visited hospitals, the doctors seemed to have shifted their view and it was a much more supportive experience.[104]

The Commission recommends building the competency of Victoria's suicide prevention and response workforces through centrally coordinated, evidence-informed training programs. These programs will focus on supporting workforces to provide compassionate, evidence-informed responses to people experiencing suicidal behaviour, no matter where they present. Currently, there is no statewide, standardised training that would better equip these workforces with these skills. Suicide Prevention Australia submitted to the Commission that an overhaul of training for the mental health workforce is much needed, saying that the lack of training is a 'major cause of delay in treating acute suicidal or other mental health crisis'[105] because of poor identification and response.

There are many workforces that need to be able to identify and compassionately respond to people experiencing suicidal behaviour. In order of priority, the training will be rolled out to emergency department, mental health and wellbeing, ambulance, police, family violence, and alcohol and other drugs workforces (refer to Figure 17.6). This will be followed by all other workforces identified as being in regular contact with community members who may be at risk of suicidal behaviour. These workforces include crisis helpline staff, general practice staff and government staff in customer service roles. The training will include regular refresher training and will be updated as the evidence evolves to ensure necessary changes to practice are made.

The training programs must be codesigned with people with lived experience of suicidal behaviour or bereavement by suicide, promote and protect human rights, and reflect the *Zero Suicides Framework* discussed in section 7.1.

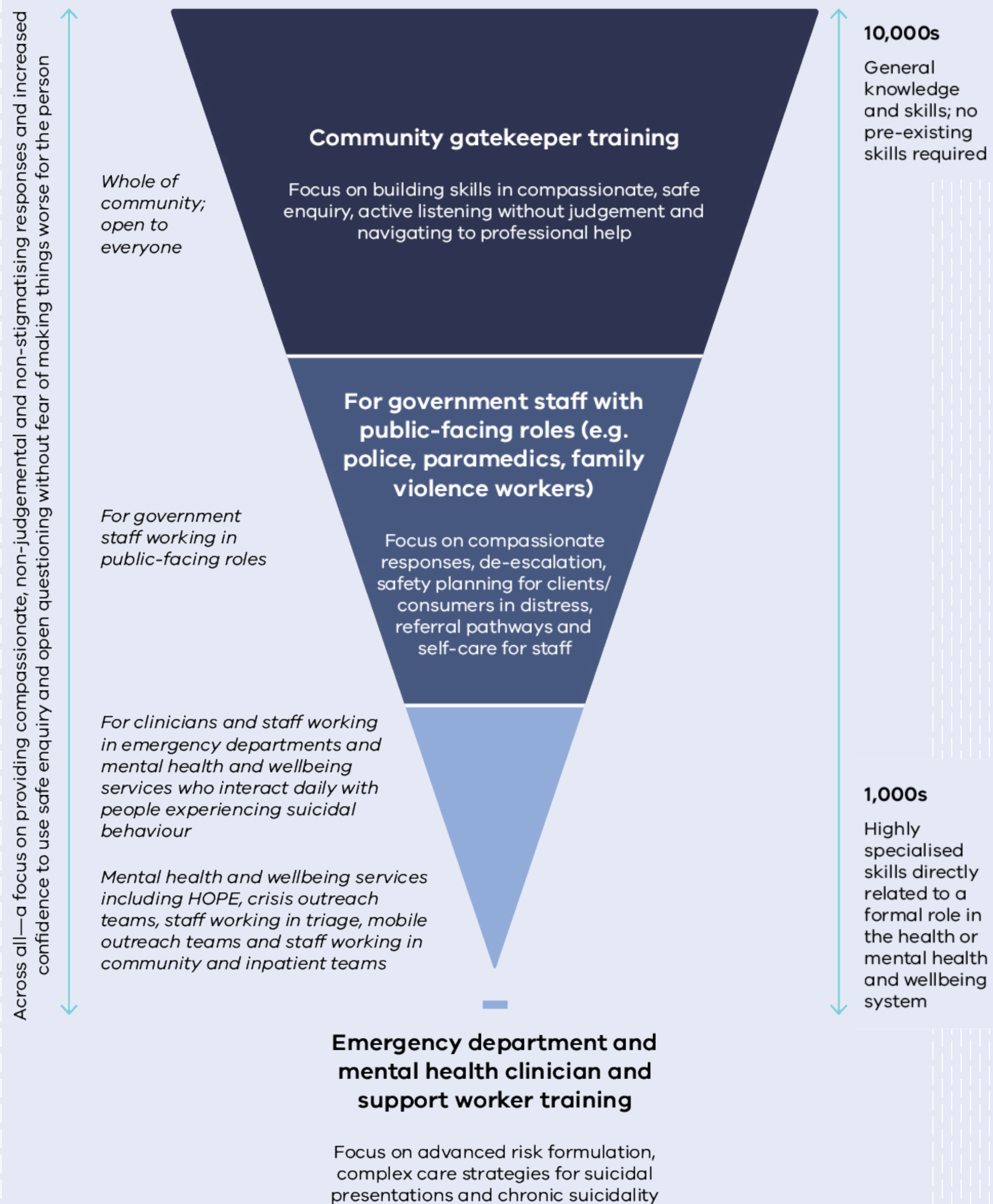
A member of the Suicide Prevention and Response Roundtable told the Commission:

> I think there's a lot of work that can be done to support our frontline and our health workers to be just better equipped and supported to work with people in crisis … I can't think of, and I haven't seen a more effective way of actually helping people understand than through lived experience. So, to be working with people with lived experience to help write new training or look at whatever great training's there, but embed more lived experience, voices, videos, people co-delivering it. I think that's how you break through and help people really truly understand what … they need to be doing to support.[106]

The Commission understands that the New South Wales Government is in the process of developing and implementing a comprehensive suicide prevention and response training program. It expects that the Victorian Suicide Prevention and Response Office will consult the New South Wales Government throughout the development of the training programs. Important features of the New South Wales draft training program include:

- a continuum of skills across workforces
- a broad reach, with an aim to train at least 20,000 people
- evidence-informed training that focuses on compassionate and stigma-free responses
- everyone in distress receiving a safety plan
- self-care for workforces
- central coordination across government
- tailored and culturally safe programs—where there is no assault, challenge or denial of identity[107]—for and led by Aboriginal people, and people from LGBTIQ+ and culturally diverse communities.

Figure 17.6: Statewide, standardised training in working with people experiencing suicidal behaviour



Pending the Commonwealth's response to the National Suicide Prevention Taskforce's initial advice regarding a workforce strategy, including contemporary training for clinical and other health staff, the Suicide Prevention and Response Office should also consult with the Commonwealth to ensure alignment and maximise opportunities to support and train the workforce.

As this recommendation involves the mental health and wellbeing workforce, the office must work closely with the Mental Health and Wellbeing Division in the Department of Health, as the entity that is responsible for developing the mental health and wellbeing workforce, to implement it.

Across this report, the Commission has sought to establish a mental health and wellbeing system and a suicide prevention and response approach based on compassion, as emphasised in the *Commissioners' reflections*. This recommendation is made with the intent that all people experiencing suicidal behaviour will receive compassionate responses, wherever they present, and workforces will feel equipped and confident to respond appropriately.

(ii) Component 2: Community gatekeeper training

As emphasised throughout this chapter, there are many factors that influence suicidal behaviour, and suicide prevention and response requires a community-wide approach where everyone has a role to play. People at risk of suicide may not seek help, but people may show risk factors that can be identified and responded to.[108]

Community gatekeepers are members of the community who may come into contact with people who are experiencing suicidal behaviour. Gatekeepers might include sports coaches, youth workers, school and higher education teachers, leaders of organised activities, retail and hospitality workers, community leaders, elders and many more. Once trained, gatekeepers will have the skills to openly and safely discuss suicidal behaviour, encourage help seeking, discuss the social factors that may have contributed to suicidal behaviour, and support people experiencing suicidal behaviour. Community gatekeepers can form a local 'safety net' in their communities and workplaces. They can also encourage connectedness across the community, where groups self-organise to discuss social factors that affect them.

This is particularly important in diverse communities, where there can be increased shame or stigma related to mental illness or suicidal behaviour. Knowledge about how to identify and respond to suicidal behaviour can help dismantle stigma within communities and can also create safe places for people from diverse communities to talk to their community leaders. Mr Adwin Town, a witness, told the Commission about the importance of equipping leaders in the Chinese community with the skills and training to help improve mental health and wellbeing in their community,[109] saying that:

> **We need to train these people to better understand mental health and to better sense the causes of poor mental health. Because ordinary people in the community turn to community leaders when they have issues with their mental health, these front-line soldiers cannot turn away from talking and learning about mental health.**[110]

Personal story:

Dave Peters

Dave's dog, Millie, has been a huge emotional support for him and also gives him a reason to get out of the house on a daily basis to exercise. This is something he finds very important, knowing the detrimental effects his medication can have on his physical health, which Dave said includes increased risk of cardiovascular disease, stroke or diabetes.

> When I adopted Millie, I did, partly, knowing that she would give me a hell of a lot of emotional support, but also that she would help me get out and exercise when that's the last thing I really feel like doing. Because I'm held accountable to someone who I love and care for.

Dave found that Millie had a lot of energy and he ended up spending a lot of time with her at the dog park. He found it helped him get over social anxieties by talking to other dog owners.

> I got to know the other dogs before other people. I feel like dogs are this great equaliser where I can more easily get over my anxiety about social interactions. Because you can talk to their dog, they can talk to you as their dog replying.

Connections Dave found at the dog park have turned into strong friendships.

> It just turned out that there was this group of four of us, spending probably three hours a day together at the park, just talking about everything and nothing really. It ended up being this great friendship.

Dave spoke about opening up to one of his friends about difficult times in his life.

> One guy worked at the Country Fire Authority. We eventually got talking about situations where people were wanting to end their lives, and talking about some of the interventions, crane rescues and things like that, that they've done at the fire authority, but also sharing my experience of being at that point of wanting to end my life.

Dave said there is a real community at the dog park, where you often hear about hardships that people are experiencing and you build meaningful connections. He said he always has someone to talk to at the dog park, and it has significantly helped with feelings of loneliness and isolation.

> Isolation has always been a bit of an issue for me. I tend to want to withdraw from the world when I'm feeling a bit wrong. I can't get away with that with Millie.

> Symptoms come and go depending on the day, and it doesn't really alleviate any symptoms, but it does provide that sense of connection to people around you that I definitely lack at times.

Following a couple of days where Dave was not at the park, one of his friends messaged to check he was okay.

> He just messaged out of the blue and said, 'I haven't seen you a few days, I just want to make sure everything's okay.' That was really nice. Here is someone that I'm just a fellow dog owner that I get along well with, just checking up on me because we've shared a lot of our lives together and shared dog company.

Dave said having Millie helps with his 'big feelings' and gives him company, but finding the community at the dog park has been 'amazing and really unexpected'.

Dave says that the feeling of isolation has been more pronounced during COVID-19, even on his visits to the dog park.

> You can't see people's facial expressions walking in the park and it is harder to talk. But even if you don't talk, there's still that feeling of being connected through our dogs. And there's always a friendly 'hello' or even the people that you don't talk to make eye contact and nod.

Source: RCVMHS, *Interview with Dave Peters*, September 2020.

Community gatekeepers are also important in rural and regional communities, where people may be more reluctant to reach out and seek help. A member of the North Eastern Victorian roundtable told the Commission:

> The rural culture and the family expectation is to say, well, we're fine, thank you. Or we're having a bit of a tough patch, but everything's under control, which is nowhere near the truth. And then when people can't hide it anymore, they just work harder. They withdraw from the community, so they don't get asked, or that or they're so busy to attend the events. When the reality is very different.[111]

Many people have told the Commission about the importance of having someone to talk to in a non-judgemental and safe space when they are experiencing suicidal behaviour, such as Dave Peters' personal story.

Ms Julie Anderson, Senior Consumer Adviser in the Office of the Chief Mental Health Nurse and Office of the Chief Psychiatrist, giving evidence in a personal capacity, told the Commission:

> I myself experience suicide ideation and the best thing for me is to be able to talk to somebody about it. It is about being able to say, 'I need to tell you this, this is what is going through my head, but it's okay, you don't need to do anything about it.' Or, 'I need to tell you when I'm at real risk of doing something about it and I need some help.'[112]

Other people shared with the Commission the importance of people in the community actively reaching out to a person who may be at risk of suicide. A person with lived experience of bereavement by suicide emphasised the importance of informal responses:

> So, it doesn't even have to be like a huge formal response. Sometimes it's the, you know, the genuine, empathetic sort of reaching out and asking the question that can make a massive difference. You know, it doesn't have to be a professional person doing that. It can be just the barista that you've gotten to know from your everyday coffee.[113]

Similarly, a mother bereaved by her son's suicide told the Commission about the importance of reaching out:

> there were a lot of opportunities for anyone to raise that conversation with my son. And it went from probably police officers to youth workers to his friends that used to play football, to school people, lots of opportunities, even myself, even myself as a mother, I never asked, and the fear that I had in me not to ask was overwhelming … It's everyone, we've all got an opportunity when we see someone who is acting differently, we know people at their core, and our instincts that when something's not right, to actually feel that we can be in that space, and ask those questions.[114]

There is emerging evidence of the value of community gatekeeper training. The World Health Organization includes community gatekeeper training as one of the critical elements of suicide prevention and response.[115] A 2009 systemic review of gatekeeper training found that it positively affects the skills, attitudes and knowledge of people who do the training, and is an 'extremely promising initiative to prevent suicide'.[116] In a 2019 evaluation of the New South Wales Shoalhaven Suicide Prevention Collaborative, of the 2,375 people who had completed gatekeeper training, 75 per cent went on to help someone experiencing suicidal behaviour within six months of completing the training.[117]

In Victoria community gatekeeper training is available in some areas through place-based suicide prevention and response trial sites, some Primary Health Networks, and the Commonwealth's Wesley Life Force. Orygen is running a 'Parent Education for Responding to and Supporting Youth with Suicide Thoughts' study, which provides online training designed to help parents and carers identify indicators of suicidal thoughts among children.[118] It also runs a 'Multimodal Approach to Preventing Suicide in Schools' project in Melbourne, including workshops that teach students to recognise and respond to the warning signs of suicide.[119] The Victorian Department of Education and Training has also funded headspace to deliver training to school leaders, school wellbeing staff and the department's health, wellbeing and inclusion workforce.[120] The 2020–21 Federal Budget also allocated $4.4 million to headspace to deliver suicide prevention training and education sessions in schools.[121]

There is, however, no coordinated and consistent approach to community gatekeeper training that is readily accessible across the state. Ms Morgan recognised gatekeeper training as an example of a Commonwealth and state government activity that lacked 'clear differentiation of roles or how the national, state and regional (Primary Health Network) funded initiatives will be coordinated'.[122]

The Commission recommends that the Suicide Prevention and Response Office co-designs or acquires an existing, evidence-informed training product and implements free, online, standardised community gatekeeper training that all Victorian adults can access. The office will also implement culturally safe community gatekeeper training that is developed and delivered by Aboriginal people.

Building the skills of adults across Victoria to compassionately and confidently identify and respond to suicidal behaviour is an important step in creating a community-wide approach to suicide prevention and response.

(iii) Component 3: Workplace suicide prevention and response programs

As conveyed throughout this report, the Commission believes that good mental health and wellbeing is a responsibility shared throughout the community. To reduce the rates of suicidal behaviour among workers in high-risk industries, workplaces need to be equipped to identify people at risk of suicide and to respond appropriately.

It is established that employment has a protective effect on suicidal behaviour.[123] However, there is also a relationship between occupation and risk of suicide. Research suggests that professionals and managers, for example, are at lower risk of suicide than labourers, cleaners or plant operators.[124] Australian research found that people in 'manual occupations, including construction workers and tradespeople, are at higher risk of suicide than the rest of the working population'.[125]

People working in particular industries may be considered to be at higher risk of suicidal behaviour due to a range of factors including workforce demographics and workplace conditions.[126] Another factor is the nature of the work, which may make it easier for someone to access the means of suicide.[127]

Case study:

MATES in Construction

MATES in Construction (MATES) is a workplace-based suicide prevention and early intervention program designed to address high suicide rates in the construction industry.

Suicide is a major health problem that is known to disproportionately affect those employed in manual occupations, including construction workers and tradespeople. Chris Lockwood, National CEO of MATES, said, 'the industry realised that it was an industry problem, and as an industry we needed to take ownership of the problem'.

Mr Lockwood said MATES uses a peer support model to help construction industry workers support each other to reduce the risk of suicide.

> The idea behind the MATES model is that we connect people to help. Rather than replicating help, we actually need to build a bridge to the help that is available.
>
> We want to equip men with the skills to approach a colleague and say, 'Mate, you're not looking too good. Can we have a chat about where you're at?' An offer like that can open up an honest conversation. Some people, and particularly men, may be a bit guarded, but you'd be surprised how people will open up when they're approached in a genuine way. Traditional suicide prevention approaches tend to focus on promoting help-seeking behaviours. Of course, that's important, but we're aiming to build on men's existing help-offering behaviours.

MATES started in Queensland in 2008 and is now active in South Australia, Western Australia, New South Wales and the Northern Territory. The program operates under a partnership, which acknowledges the shared responsibility between workers, industry partners and government. It obtains funding from a diverse pool of sources that include state redundancy funds, direct industry funding, governments and grants.

> For MATES in Construction, the need to work with the industry meant getting the unions and the employers on board, and having them agree to roll out a program that was industry-wide. We wanted the program to become a normal part of the construction industry, and not be particular to any one business.
>
> The success of MATES is largely delivered through this genuine partnership which builds trust in the program from the workers and the broader construction community, seeing buy in from all to make a genuine difference.

MATES provides on-site training to encourage help-seeking and early intervention through people called 'Connectors'. Connectors are trained in suicide first aid and are supported by outreach, case management, and a 24-hour telephone response line. There is also a postvention component for suicide and industrial deaths.

A number of peer-reviewed, published evaluations of MATES have been completed, and all have shown positive outcomes. These include an increase in workers having favourable attitudes about the workplace's role in confronting mental health issues and suicide; positive changes in suicide prevention awareness, knowledge and attitudes; and an increase in workers seeking help and treatment.

Feedback on MATES from construction workers is positive, with one worker commenting:

> MATES was great at keeping in contact and checking in with me to make sure I was ok, while I was going up and down with my emotions and situation and making sure I stayed positive and could see a way forward.

Sources: *Witness Statement of Chris Lockwood*, 27 May 2020; Allison Milner, Heather Niven and Anthony LaMontagne, 'Suicide by Occupational Skill Level in the Australian Construction Industry: Data from 2001 to 2010', *Australian and New Zealand Journal of Public Health*, 38.3 (2014), 281–285; Professor Chris Doran and others, *An Evaluation of MATES in Construction: Queensland Case Management*, 2019.

Two examples of higher risk industries are:

- **Construction:** Between 1979 and 2012, a meta-analysis of international studies suggested that suicide rates among 'workers in construction were 80 per cent higher than for the general working age population'.[128] In this industry, risk factors include socioeconomic factors[129] and work-related stressors, including job insecurity such as short-term contracts; a fluctuating job market; long work hours; workplace bullying; and the use of alcohol and drugs in the workplace.[130]
- **Agriculture:** Australian research suggests that male suicide rates in the agricultural industry range from 33.8 per 100,000 people to 51.4 per 100,000 people.[131] Research has indicated that stressors unique to farming, such as long work hours, social isolation and climatic variability, may negatively affect mental health and contribute to suicidality.[132]

The Commission recommends that the Suicide Prevention and Response Office facilitates Victorian industries and businesses to invest in workplace suicide prevention and response programs, with an initial focus on forming partnerships with high-risk industries to implement evidence-informed programs. Programs should focus on worker-led initiatives, informed by people with lived experience of suicidal behaviour and bereavement by suicide.

An illustrative example of a successful workplace suicide prevention and response program is MATES in Construction, as outlined in the case study.

17.6.2 LGBTIQ+ model of aftercare service following a suicide attempt

The Commission understands that people from LGBTIQ+ communities may be at particular risk of suicidal behaviour. Research has established that people from LGBTIQ+ communities experience higher rates of suicidal thoughts, self-harm and poorer mental health compared with heterosexual and cisgender populations.[133]

Research undertaken by the Australian Research Centre in Sex, Health and Society in 2020 with people from the LGBTIQ+ community found that 41.9 per cent of adults surveyed reported that they had considered attempting suicide in the previous 12 months, which is almost 20 times higher than the rate reported in the general population.[134] Further, 5.2 per cent of adults surveyed had attempted suicide in the previous 12 months, which is 10 times higher than the rate of attempted suicide observed in the general population.[135]

Victoria's Coroners Court data show that between 2009 and 2016, among 4,791 suicides, there was evidence that in 172 deaths (3.6 per cent) the person identified as LGBTIQ+.[136] LGBTIQ+ identity may be underreported though, as it relies on statements from family and friends about gender and sexual identity.[137]

There are added dimensions to the way LGBTIQ+ people experience mental health and wellbeing, and in some instances suicidal behaviour can be connected to an individual disclosing their sexuality.

Commissioner Ro Allen, Victorian Commissioner for Gender and Sexuality (now known as the Commissioner for LGBTIQ+ Communities), told the Commission:

> **From LGBTIQ people who have attempted to end their own lives, we know that they often attempt suicide before having disclosed their sexuality or gender identity to other people. In other cases, family members or loved ones who do know the sexuality or gender identity of someone who has died by suicide may elect not to share this information with officials.**[138]

The reluctance of people from the LGBTIQ+ community to access mainstream services can be a compounding factor that contributes to the suicides among people who identify as LGBTIQ+. Australian research undertaken in 2019 with 472 people who identified as LGBTIQ+ found that 71 per cent of participants chose not to use a mainstream crisis support service (such as police, ambulance and crisis phone lines) during their most recent personal or mental health crisis.[139]

Barriers to accessing crisis support services that were identified included:

- anticipation of discrimination
- 'not wanting to be a burden' narratives
- lack of awareness of mainstream crisis support services, LGBTIQ+ specialist counselling or mental health support services
- physical, technological and financial barriers.[140]

People from the LGBTIQ+ community who are at risk of suicide need a culturally safe and uninterrupted care pathway to support their recovery.[141] It has been submitted to the Commission that there is a need for a statewide LGBTIQ+ community-controlled aftercare service (services for people who are experiencing suicidal behaviour or who have attempted suicide) for the most at-risk help-seekers to ensure they do not fall through the gaps.[142]

The Commission understands that as one of the 12 suicide prevention place-based trials across Victoria, North Western Melbourne Primary Health Network has co-designed and established a community-based aftercare service for LGBTIQ+ people. Delivered by Mind Australia, the service is open to people experiencing suicidal thoughts or who have made suicide attempts, and accepts referrals from a wide range of settings, including general practice, family, friends and self-referrals.[143]

The service has trialled 'Aftercare Groups', which provide weekly, continuing support with the aims of reducing social isolation, strengthening community connection, and developing ongoing self-care strategies.[144] Based on positive feedback, the groups will be implemented in this aftercare service.[145] The program also provides counselling-based support to the chosen families and carers of people who have experienced suicidal behaviour.

In addition to a range of preventative measures, such as workforce and gatekeeper training, the Commission recommends that the Suicide Prevention and Response Office co-produces an aftercare service specific to LGBTIQ+ people, to be offered following a suicide attempt, that is tailored to young people and adults.

A participant in the Suicide Prevention and Response Roundtable told the Commission:

> What I think about in Victoria about the structure—structurally, is that, you know, we need to have formal recognition that LGBTQ+ people are a priority population around suicide prevention. It certainly hasn't happened nationally, glaringly nationally, and it hasn't formally happened in Victoria either.[146]

The office will work with local communities and relevant interested parties to understand the potential demand for the aftercare service. It will select three to five geographic areas where there is the highest need for face-to-face aftercare services for LGBTIQ+ people, and co-produce innovative options with LGBTIQ+ young people and adults, such as telehealth and online services, to enable the service to be rolled out statewide over time.

This initiative will harness the lessons learnt from the service established by North Western Melbourne Primary Health Network, including the use of peer workers who identify as being from the LGBTIQ+ community.

While the lessons from the evaluation of Victoria's flagship aftercare service, the HOPE program, will also be considered, it is expected that an aftercare service for LGBTIQ+ Victorians will be fundamentally different. For example, it will involve self-referrals and referrals from LGBTIQ+ organisations such as Switchboard and offer aftercare services for all forms of suicidal behaviour. Further, it will be delivered through the non-government sector.

LGBTIQ+ Victorians should have access to safe and responsive aftercare services that are tailored to the needs of the LGBTIQ+ community.

17.6.3 Statewide postvention bereavement support

Grief following a loved one's suicide can be profound. The emotions experienced can differ considerably from the grief felt following other types of deaths, particularly when people experience stigma and isolation because of the way a loved one died. The Commission has heard from many people about the unique experience of this grief.

Ms Kouselas told the Commission:

> No one understands it unless you have lost someone to suicide. It is very isolating. It is not like losing a loved one to something else. It is like you have a big sign on your back and no one knows what to say.[147]

Ms Susan Trotter, a witness, shared a similar experience of bereavement by suicide:

> At first, no one seemed to really understand what I was going through at all. A GP tried to put me on anti-depressants, but I knew I was not depressed—I had lost my son so of course I was upset. I saw counsellors a few times, but felt like they never really got it. I also attended a few group counselling sessions with other bereaved parents, but I felt like I was going through a very different process to parents who had lost a child to cancer, for example.[148]

Another unique factor may be a sense of guilt and prevailing questions about *why*. Dr Louise Flynn, Manager of Support After Suicide at Jesuit Social Services, told the Commission:

> The people I have worked with often say that they feel guilty, or they feel like they failed the person, or that they have let them down; they question whether they caused it or could have prevented it. A person bereaved by suicide often has a relentless and distressing experience of trying to understand how it could have happened.[149]

Research suggests that people who are bereaved by suicide are at risk of suicidal behaviour and poor mental health.[150] Australian data released in 2019 showed that of the 3,127 suicides in 2017, 18 were suicides of people who had been bereaved by a suicide in their immediate network of family and friends.[151]

Postvention bereavement services are a range of supports provided to those who have been bereaved by suicide. The Commission believes that all Victorians bereaved by suicide should have access to evidence-informed postvention bereavement services to reduce their risk of suicidality and poor mental health. While there are some well-regarded postvention bereavement services operating in Victoria, these services are only available in limited areas, with limited access, and there is no statewide coverage.

The only funding the Victorian Government currently provides for postvention bereavement services was once-off funding to Switchboard in 2019–20 to provide specialist bereavement support for LGBTIQ+ people bereaved by suicide.[152]

Dr Flynn told the Commission about the limited availability of postvention bereavement services:

> In my view, there are not enough services available in Victoria for people bereaved by suicide. This is the case in metropolitan Melbourne, and even more so in regional and rural areas. While [Jesuit Social Services'] Support After Suicide operates in some regional areas, its ability to provide robust services, in spite of increased demand, is limited due to restricted funding.[153]

Dr Flynn reported that Support After Suicide, receives no state government funding, stating:[154]

> To better assist people bereaved by suicide, in my view, the Victorian Government needs to commit to secure and expanded funding for postvention, early intervention services for suicide bereavement, including Support After Suicide.[155]

A family member bereaved by suicide echoed Dr Flynn's comments, telling the Commission about the challenges of using postvention bereavement services due to their geographic location:

> It just wasn't there when I needed it. And I also found, I guess, having it only in certain locations, and if there's travel between the time that you spend, you know, divulging your grief and feeling really quite distressed, and then having to drive home again, I found that a little bit of a barrier sometimes in my willingness to want to go, and because I know, I mean, generally, a session like that, it's [going to] wipe you out probably for the rest of the day.[156]

In a survey carried out by Jesuit Social Services with 142 family members whose loved ones had died by suicide,[157] several families said they needed to seek out assistance, rather than having help offered automatically,[158] and in survey comments, family members described being offered 'extremely limited assistance immediately after the suicide, or assistance that was inconsistent or ad hoc'.[159]

For those who do access postvention bereavement services, there is evidence of its positive impact, as illustrated in Julie Rickard's personal story.

A 2017 survey was undertaken with 545 people bereaved by suicide, comprised of people who had accessed StandBy Support After Suicide (a national, community-based postvention service), people who had received support from other sources (such as a support group, GP or psychologist), or people who had received no support at all. Results showed that those who had received StandBy postvention services:

- had a reduced risk of suicide (38 per cent compared with 63 per cent)
- had fewer mental health concerns (38 per cent compared with 74 per cent)
- were significantly less likely to experience a loss of social support and experience loneliness (28 per cent compared with 50 per cent)
- had fewer instances of difficulty sleeping, financial distress, family breakdown or problems in the workplace.[160]

The Commission recommends that, through a partnership with the Commonwealth Government, all children, young people and adults that have been bereaved by suicide are automatically referred to postvention bereavement support.

Under this initiative, all people who are bereaved by suicide will be automatically referred to a postvention bereavement provider, subject to consent, through the existing Victorian Police E-Referral System.

The Suicide Prevention and Response Office must work in partnership with the Commonwealth in implementing this recommendation, noting its role in postvention service delivery and the National Suicide Prevention Taskforce's initial advice that communities should have more coordinated and timely postvention responses.[161] The Commonwealth already invests in postvention bereavement services in Victoria, including for secondary school students through headspace in Schools,[162] with funding announced in the 2020–21 Federal Budget.[163] In establishing statewide coverage of postvention bereavement supports, it will be important for the Office to coordinate efforts with the Commonwealth to maximise existing investments, especially where supports are already well established, such as in schools.

To implement this recommendation, where there is evidence of a suspected suicide, police will need to compassionately recommend postvention bereavement support to family and friends of the deceased at the time of death, and obtain their consent to make an automatic referral to a postvention bereavement provider. This will be standard practice in these circumstances. The Commission is aware through data supplied by Victoria Police that the Victorian Police E-Referral System is capable of enabling these referrals: in 2019, police made 730 referrals to postvention bereavement providers.[164]

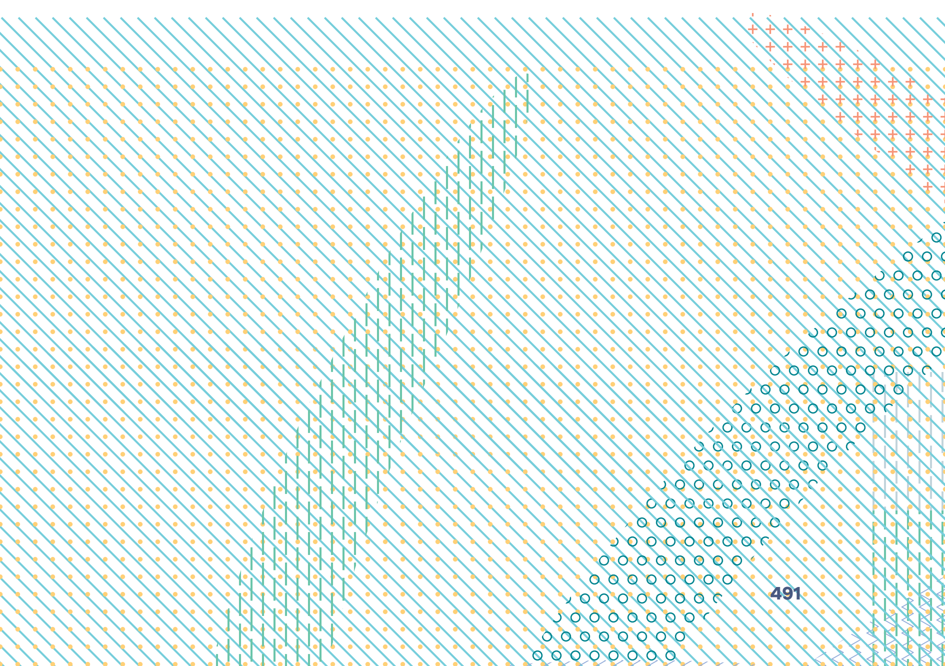
The Coroners Court of Victoria also has contact with a deceased's family and friends and will be another point of referral into postvention bereavement supports. This will give families and friends who declined the referral from the attending police a second opportunity to accept professional support. Grief affects people differently, and some people might not be ready to accept support straight away.

To ensure culturally safe responses, the social and emotional wellbeing teams in Aboriginal controlled-community health organisations, which the Commission's interim report recommended, will provide postvention bereavement support services for Aboriginal people. The Victorian Aboriginal Community Controlled Health Organisation reported to the Commission that post-suicide interventions, attached to Aboriginal controlled-community health organisations, were an immediate priority.[165]

The Commission suggests that statewide coverage is achieved via an innovative combination of face-to-face and digital delivery, including individual, family and group sessions. Peer support workers with a lived experience of bereavement by suicide will be included in the multidisciplinary teams that deliver these services.

The Office will need to consider the most effective and efficient way to ensure the service is available seven days a week. The Commission considers it important that contact is made with those bereaved as quickly after the event as possible, ideally within the first 24 hours.

Victorians who are affected by loss and grief after a loved one's suicide should be properly supported. Postvention should be available to everyone who has been impacted by the death, not just the next of kin, and there should be no limit to when the help has to be sought by, or for how long.



Personal story:

Julie Rickard

Julie lost her partner, Steve, to suicide following a decline in his mental health after a workplace accident.

A week before Steve died, Julie said she noticed a significant change in his behaviour and sought help through Steve's GP.

> Steve was pulling his hair out in chunks and he stopped eating. He wouldn't sleep. His behaviour changed completely and I had no experience with dealing with this before so I made an appointment for Steve to see his GP. Steve had a great relationship with his GP, who could see he was not well.

Steve's GP made a follow-up appointment a few days later and provided some information about other services, but his GP was not local and they found that Steve was out of catchment for many of the services.

A few days later Julie said she knew Steve 'was not right' and called an ambulance. Julie felt her concerns were dismissed by clinicians in the emergency department and by the Crisis Assessment and Treatment Team that visited Steve the following day.

> I was literally begging them saying, 'he's not right, I'm really concerned about him.' And I'll never ever forget this, she turned around and said to me, 'he says he is fine. I'm worried about you'.

Julie would like to see a mental health system with a more collaborative approach, where family members' opinions are recognised and heard.

> Listen to the people in someone's inner circle because they know that person the best, they know when that person is irrational and not making sense. Listen to the people around them.

Following Steve's death, Julie sought support from a specialist suicide bereavement service.

> I initially had one-on-one counselling, and that was fantastic. They came out to my area to see me so I only had to drive five minutes away. It was targeted support because suicide grief is different; you've got guilt, you've got anger, you've got questions.

Julie said that it is critical that support is provided close to home. She attended some group sessions, but found that travelling to the groups was challenging.

> It was hard enough to get up and get dressed, getting in the car and driving 45 minutes felt like climbing Mount Everest. It just seemed an almost impossible task. I found the long drive home to an empty house was more distressing than any support I got at the group.

Julie spoke of the importance of support being consistent, reliable and not time-limited to provide some certainty 'when your whole world has been turned upside down'.

> Everybody grieves differently and everyone takes different amounts of time. It is good to know the support is open ended. I was also seeing the same person. I think that's really important, to be able to build a relationship with someone and not have to be re-explaining yourself over and over again.

Julie also said she was happy with the support she received from the police, but noted that it would also have been helpful to have been given an explanation of the process with both the coroner and the police.

> No one explained to me that in one or two months, the police will ring you and you'll need to go in and do an interview.
>
> The police woman who attended on the day and when I went in to do the police interview was fantastic. She actually called me a couple of times afterwards to check in.

Source: RCVMHS, *Interview with Julie Rickard*, August 2020.

17.6.4 Improved support for people experiencing psychological distress

As explored throughout this chapter, the causes of suicide and suicidal behaviour are complex, varied and interrelated—mental illness is not always a factor in suicide, and many people who die by suicide do not have a diagnosed mental illness.

Ms Morgan emphasised this point:

> Suicide is not only a mental health issue; there are periods in life that may be inherently stressful due to the disruption they create to a person's identity or support networks. These transitions may include: progressing from primary to secondary [school] to post-school education or the workforce; changing employment or employment status (including retirement); becoming a parent; and experiencing a family breakdown, loss or grief.[166]

Suicide prevention and response must take a broad approach to those who are experiencing psychological distress and may be on a path to suicidal behaviour.

There is a large gap in Victoria's suicide prevention and response efforts for people who are experiencing psychological distress. Most initiatives focus at either end of the care continuum, such as prevention and aftercare, with little support offered to those in distress who may be at risk of suicidal behaviour. A service for people in psychological distress balances this focus and allows for social factors to be addressed through an early intervention process.

Ms Morgan's initial advice to the Prime Minister supported this type of approach:

> Moving to a distress-focused, early-intervention approach with appropriate care coordination and follow-up care would better meet the needs of individuals and their families.[167]

Beyond Blue also supported a focus on assisting people to 'stabilise and recover from distress',[168] and Ms Harman told the Commission:

> There are also many people who experience forms of psychological distress that may serve as early warning signs of suicidality. Intervening early with the right support can help these people before they escalate into crisis.[169]

The Commission recommends that the Suicide Prevention and Response Office develops and implements an intensive 14-day program of support for people who are experiencing psychological distress, with a low threshold to entry and multiple referral pathways into the program, including through emergency and social services. The program should include people with lived experience of suicidal behaviour in its design, implementation and delivery.

The recommended program will be modelled on Scotland's Distress Brief Intervention program (refer to Figure 17.7 and Distress Brief Intervention case study). Scotland has pioneered this program, with an independent evaluation of the program showing positive early results.

Important aspects of the Scottish program that the Commission recommends are adopted include:

- recognising a broad range of drivers for psychological distress, including relationship breakdowns, financial difficulties, major physical injuries, social isolation and poor mental health
- access and support, regardless of what is causing the person's psychological distress
- a low threshold to entry, with people welcomed and treated with compassion
- multiple referral pathways in, including through police, justice and legal services, ambulance, family violence services, mental health and wellbeing services, alcohol and other drug services, crisis phone lines and social services, and also through self-referral
- delivery by the non-government sector, through multidisciplinary teams with peer workers who are highly valued
- a balance of face-to-face (in-home appointments and those at the providers' premises) and digital delivery
- a focus on intensive support for the 14 days, with connections established to continuing supports in the person's local community
- flexibility regarding the 14 days to allow for people who might need less time or a little more.

The program will initially start as a proof of concept in one metropolitan and one regional area, targeting areas that have the highest rates of psychological distress. Following a 12–18-month period for evaluation, provided there is evidence of positive outcomes, the Suicide Prevention and Response Office should consider scaling the program. The Commission also notes that, in 2019, the Scottish program was extended to people aged 16 and 17 years,[170] and recommends that this is considered as part of scaling the Victorian program.

As the recommended program has a close connection with crisis responses, such as the recommended safe spaces and other initiatives in Chapter 9: *Crisis and emergency responses*, the office will develop and implement the program in partnership with other parts of the Department of Health and Regional Mental Health and Wellbeing Boards, to ensure there are coordinated responses to people in crisis, and that there is no duplication of services.

Subject to the Commonwealth's response to the National Suicide Prevention Taskforce's initial advice regarding scoping options to establish a Distress Brief Intervention program in Australia, the office must work with the Commonwealth to ensure its work is complementary and opportunities to work collaboratively are optimised.

Case study:

Distress Brief Intervention

Distress Brief Intervention is a time-limited intervention (generally less than 14 days) that provides support for people in psychological distress.

Distress Brief Intervention was developed in Scotland to improve frontline service providers' response to people presenting in distress. Professor Rory O'Connor, Director of the Suicidal Behaviour Research Laboratory at the University of Glasgow and member of the program board, said the rationale for the program was to 'catch people who are falling through the gaps who don't necessarily have a mental health diagnosis'. The program is a collaboration of government (health and emergency) organisations and community-based organisations.

Distress Brief Intervention has two levels:

- Level 1: Trained frontline staff (including police, paramedics, emergency department staff, mental health clinicians, substance abuse nurses and GPs) assist people in distress and then ask if they would like further support. If they agree, they are referred to the Distress Brief Intervention service, which will contact them within 24 hours to start providing further face-to-face support.
- Level 2: Trained community sector staff contact the person within 24 hours of referral and provide community-based problem-solving support, wellness and distress management planning, supported connections and signposting to other services.

Level 2 services can support consumers with issues such as homelessness, loneliness, relationship issues, bereavement and family violence and connect them to other relevant support organisations, often directly targeting the cause of the distress.

The program defines distress broadly as 'an emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response', which means support can be offered to a wide range of people, even before defining the source of their distress.

An independent evaluation for Distress Brief Intervention is currently underway, with interim findings showing positive results in a wide range of areas including the following.

Compassion
The Distress Brief Intervention vision is 'connected compassionate support', which underpins the approach of shared commitment to collective action. Most participants in the evaluation reported receiving high levels of compassion in their interactions with frontline services (Level 1).

Noting this, Professor O'Connor said, '[c]ompassion is at the heart of everything that we do within the Distress Brief Intervention program, from the first contact that a person has with frontline staff to the delivery of the Level 2 support'.

Long-term benefits
Despite Distress Brief Intervention being a short-term intervention, it may also improve a person's long-term capability to manage distress as well as motivation to find a way forward.

> Preliminary indications suggest that the [Distress Brief Intervention] programme is providing a starting point for individuals to learn how to understand, manage and seek help effectively for their distress, who otherwise report they would turn to primary care, medication, unhealthy coping skills or suicidal behaviour.

Collaboration
The nature of the program has also brought benefits for collaborative professional environments.

> the [Distress Brief Intervention] programme is developing highly effective cross-sectoral working and extended professional networks both within and across the pilot sites … and provides an excellent example of cross-sectoral working, which is often hard to achieve.

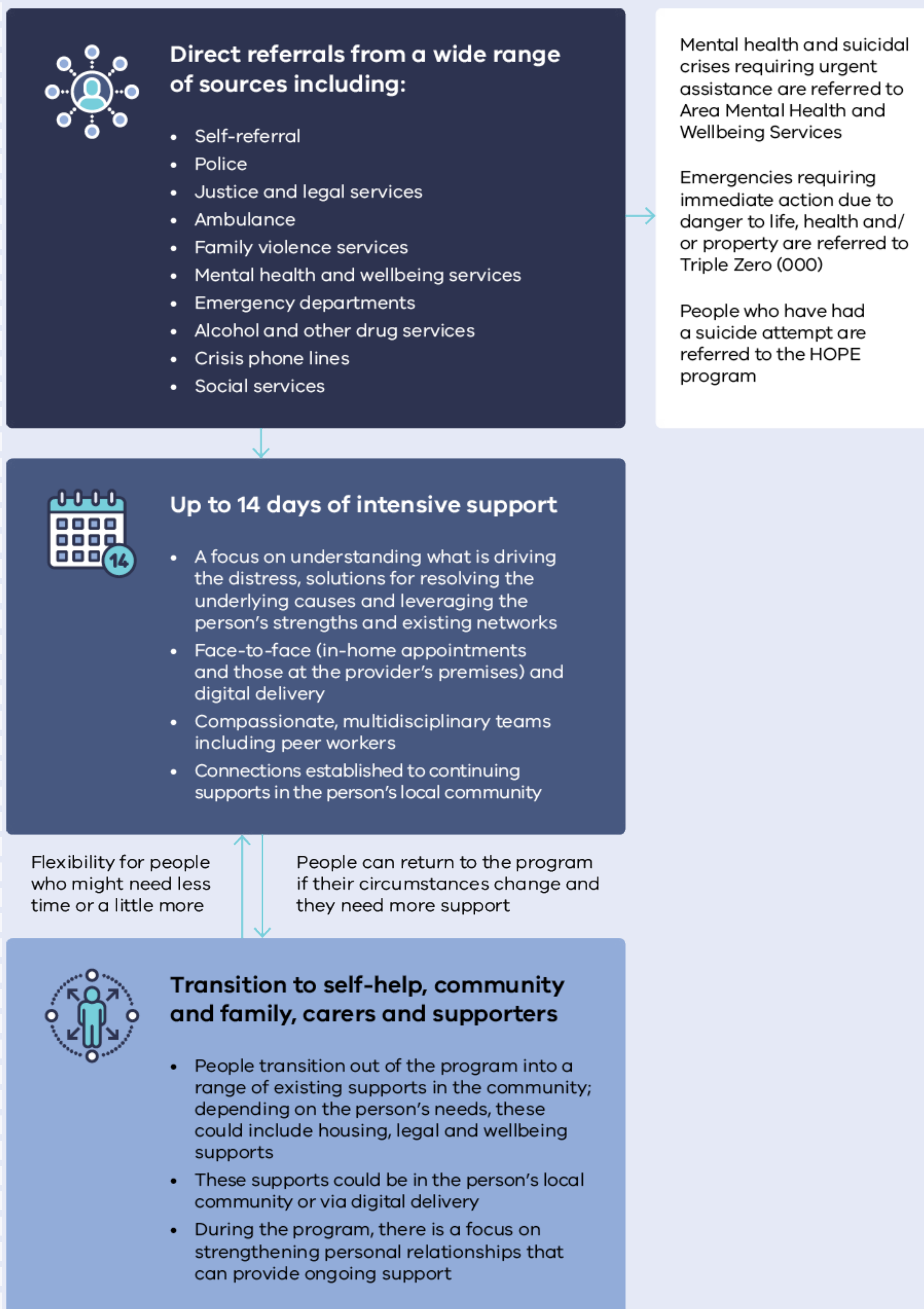
The Distress Brief Intervention pilot began in 2016 and was scheduled to run until March 2021. However, as part of the Scottish Government's COVID-19 response, Distress Brief Intervention has been funded to operate nationwide through the NHS24 Mental Health Hub (a phone helpline) as a Level 1 entry point. The Scottish Government recently announced that the program would be piloted to 14- and 15-year-old children through their school and child and adolescent mental health services.

Although a relatively new program, more than 12,000 people have been through Distress Brief Intervention in some form, including 19-year-old Julia. Following a series of personal setbacks, Julia attempted to end her life. A Distress Brief Intervention trained nurse asked Julia if she would like to be referred to the program. Julia found the program has helped her cope better with life.

> I wasn't sure what to expect, but I was very impressed with the rapid response I received. It was really helpful having someone to talk to and help me work through all the issues that were making me feel the way I did and better understand them.

Sources: RCVMHS meeting with Professor Rory O'Connor, 14 September 2020; Dr Edward Duncan and others, *Evaluation of the Distress Brief Intervention Programme: Interim Report*, 2020; Distress Brief Intervention, 'Aim' <www.dbi.scot/aim/>, [accessed 19 August 2020]; Scottish Government, 'Media Release: Mental health pilot project extended', 2019, <www.news.gov.scot/news/mental-healthpilot-project-extended>, [accessed 19 August 2020].

Figure 17.7: Intensive 14-day support program for adults who are experiencing psychological distress



17.7 Initiatives for the new suicide prevention and response strategy

The following suicide prevention and response initiatives are expected to be included in the new suicide prevention and response strategy for Victoria and funded over time.

17.7.1 Eliminating the suicides of Victorians receiving treatment, care and support in health services

The death of a loved one by suicide during a hospital admission causes immense distress to families, carers and staff. Changing the way in which people are received, treated and supported through the health system provides an opportunity to prevent suicides of Victorians accessing both mental health and broader health services.[171]

The *Zero Suicides Framework* was developed in the United States to prevent suicides in health care. This includes systematically adopting evidence-informed approaches—such as ongoing risk assessment and screening, collaborative safety planning and consistent engagement—across the health service. The approach is implemented via seven components: four relate to clinical care (Identify, Engage, Treat and Transition) and three relate to service and system-focused approaches (Lead, Train and Improve).[172] The framework is often implemented alongside a just and restorative culture.[173]

New South Wales Health has developed a 'zero suicides in care' strategy to 'support staff in the mental health system to redesign procedures, reduce risks and build skills to prevent suicide among people in acute and community based mental health services'.[174]

Latrobe Regional Hospital has also implemented this approach locally. The hospital told the Commission:

> [Latrobe Regional Hospital] has been implementing the [zero suicide] approach over the last 18 months and has actively engaged with and visited sites in the USA, New Zealand and the Gold Coast to support our work. Since implementation, we are seeing changes in clinical practice, such as increased safety planning for patients and follow up and treatment for people who ordinarily would have fallen through the gaps in the healthcare system.[175]

There is scope to trial the implementation of the *Zero Suicides Framework* in more health services across Victoria. Rollout of the framework includes workforce training, which will complement the broader suicide prevention and response workforce training recommended by the Commission.

The Commission expects that health services will be supported to implement the *Zero Suicides Framework*, with support provided by the Mental Health Improvement Unit within Safer Care Victoria.

17.7.2 Establishing suicide prevention local alert systems

While suicide clusters are relatively rare, they can have a profoundly negative impact on other people and on the community, 'largely due to the risk of further suicides, complicated grief reactions and the potential for ongoing distress and trauma'.[176] Research suggests that news about a suicide can spread rapidly across communities, and this can cause heightened fear, anxiety and distress for some people.[177] Research also suggests that youth suicides, as opposed to adult suicides, more commonly occur as part of a cluster.[178]

Victoria does not have a consistent approach across the state to provide local communities, stakeholders and service providers with real-time[179] data on potential clusters of suicide attempts and deaths.

Ms Harman told the Commission about the importance of having access to real-time data to:

> enable local services, communities, first responders, health services, mental health services [and] schools, to be identifying emerging clusters of suicide, for example, and then to wrap around supports for a school community, for example, where there might be a spate.[180]

Similarly, Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, giving evidence in a personal capacity, told the Commission that there is an urgent need for access to real-time data on the statewide and national levels for all age groups so that immediate postvention responses can be implemented.[181]

In comparison, New South Wales has incorporated real-time data into its state suicide prevention and response strategy and is currently trialling a suicide risk alert system in local communities to ensure there is a rapid, localised response to people at imminent risk of suicide.[182]

The highly regarded Victorian Suicide Register means the state is well placed to provide regular data on suicide deaths by geographic region. The Commission notes that there is currently no similar infrastructure to provide real-time data on suicide attempts. That being said, it recognises that the National Ambulance Surveillance System partnership between Turning Point, Monash University and Eastern Health in Victoria provides timely data on ambulance attendances for suicidal behaviour.[183] This is part of the Australian Institute of Health and Welfare's and the National Mental Health Commission's national suicide and self-harm monitoring system.[184]

The Commission expects that suicide prevention and response local alert systems will be established across Victoria by the Suicide Prevention and Response Office in collaboration with relevant stakeholders. These systems will bring local stakeholders and service providers together to use real-time data to trigger and develop a tailored, comprehensive service response when there has been a suspected suicide cluster or elevated rates of suicide attempts. Local stakeholders and service providers could include teachers, health and mental health and wellbeing professionals, police, ambulance, local media and community leaders.

If real-time data are made accessible and used sensitively, stakeholders can work together in identifying clusters or emerging clusters. This in turn will enable them to enact preventative and recovery supports such as additional mental health and wellbeing services. Suicide prevention local alert systems will aim to prevent clusters, reduce the potential for further harm and promote recovery as quickly as possible.

17.7.3 Supporting communities to implement localised suicide prevention activities through a grants program

Communities can provide important protective factors against suicide such as a sense of belonging and purpose, rallying around people when they experience circumstances that may place them at increased risk of suicide, and being at the frontline of identifying and supporting people experiencing suicidal behaviour.

This is particularly important in rural and regional communities, where a sense of community spirit and social connectedness can have a positive impact on people's mental health and wellbeing.[185] Environmental factors, such as climate change, extreme weather events and natural disasters, can negatively affect people's mental health,[186] but local communities are well placed to participate in and lead change that builds on the community's strengths.

A mother bereaved by her son's suicide highlighted the importance of community members rallying around each other and talking openly about suicide:

> I knew that the chances of my son's friends and acquaintances going on to take their lives had increased significantly. And I did not want that to be his legacy, I did not want that for him and he would not have wanted that. So I went on to take a group of his closer friends out for some equine therapy, and I got support from some people with money out here … And I thought … why can't we open that up to other people? [So,] at the end of 2018, I held an event to raise money to send other young people for these things. But what I made it was a community event … So, the young people saw this community of people that they didn't realise how much they actually cared that's like, okay, that's a person I can go talk to.[187]

Regarding Victoria's local approaches to suicide prevention and response, Mr Woodward told the Commission that Victoria 'is lagging behind other states'. He pointed to South Australia as a positive example of 'building capacity for suicide prevention close to the local factors that need to be addressed, across government, private and community sectors, and with a coordination function set at the highest level'.[188]

In South Australia, Suicide Prevention Networks, comprising the Office of the Chief Psychiatrist, local government and the community, are given annual funding for local suicide prevention and response initiatives.[189] The central leadership and resources ensure that while each network is unique to its local context, all networks work to the same basic model, framework and evidence base.

The Commission expects that communities across Victoria will be supported on an opt-in basis to support local responses to suicide prevention through a range of evidence-informed, strength-building activities. This should be supported through an annual grant program, via grants of up to $10,000, in line with the South Australian program.

In undertaking this grants program, the Suicide Prevention and Response Office should work closely with the Mental Health and Wellbeing Division that will implement the 'community collectives' in each local government area across Victoria that are recommended in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, as well as the new Regional Boards recommended in Chapter 5: *A responsive and integrated system*.

17.7.4 Further strengthening the HOPE program by extending referral pathways

There is evidence that one of the most effective ways to reduce the suicide rate is to provide follow-up care to people who have attempted suicide, given that this is one of the biggest predictors of a future suicide attempt.[190]

Many people have told the Commission about the importance of aftercare following a suicide attempt. A person with lived experience of suicidal behaviour highlighted the importance of aftercare services:

> Now, my big push always is trying to reconnect people, you know, you have normally finally withdrawn, so there's only you. When you get out, you're going to reconnect. And a lot of people you want to reconnect with, don't think you want to, but also, you're not in the mindset to do it. So you really need someone to hold your hand and ease you back into society.[191]

The Productivity Commission's *Mental Health Inquiry Report* also recognised the effectiveness of aftercare services and recommended, as a priority, that Commonwealth, state and territory governments should offer 'aftercare to anyone who presents to a hospital, GP or community mental health service following a suicide attempt'.[192]

While the Commission's interim report recommended expanding the HOPE program, including referral pathways in from clinical community-based teams within current area mental health services, the opportunity to further broaden the referral pathways so they cover all potential interactions with someone who has attempted suicide should be considered.

Currently, the HOPE program can only receive referrals from emergency departments and, based on the Commission's interim report recommendation, from area mental health services. People who have attempted to take their own life, however, may seek help from a variety of settings, and many people may be reluctant to present at emergency departments. The HOPE evaluation also found there is opportunity to expand referral sources beyond hospital-based referrals to include other parts of the public health system, to support more people.[193]

The Commission proposes that, based on demand modelling and the capacity of the HOPE program to expand, consideration should be given to expanding the HOPE program's referral pathways to all services and workforces where there are potential interactions with someone who has attempted suicide. This should include consideration of general practice, police, ambulance, crisis helplines, alcohol and other drug services, family violence services and private psychologists and psychiatrists.

17.8 Continuously improving Victoria's approach to suicide prevention and response

As the evidence base for suicide prevention and response initiatives is still emerging, the Suicide Prevention and Response Office will embed evaluation processes in all the recommended initiatives, and continually adapt and improve its approaches.

Professor Pirkis told the Commission:

> **As a part of [strengthening the evidence base], promising novel interventions should be trialled and implemented, even if there are gaps in the evidence base. However, to do this safely and measure the effectiveness of these strategies, there is an onus on those who are funding and delivering them to conduct meaningful evaluations as [the strategies] are rolled out.**[194]

The recommended governance structures will also be periodically reviewed and revised to ensure they are meeting the objectives of a truly whole-of-government approach, where multiple stakeholders are held to account and are working collaboratively.

This work will link to the Commission's recommended approach to creating an adaptive mental health and wellbeing system based on continuous improvement, evaluation, innovation and research. In particular, the evaluation of the suicide prevention and response programs links to the Commission's recommendation that the Department of Health establishes a rolling strategy for program evaluation, which will lead system innovation and evaluation activity, as set out in Chapter 36: *Research, innovation and system learning*. An adaptive suicide prevention and response approach will be vital to progressing *towards zero suicides*.

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2 *Evidence of Associate Professor Peter Burnett*, 23 July 2019, p. 1570.

3 *Witness Statement of Georgie Harman*, 1 July 2019, para. 86.

4 *Evidence of Professor Jane Pirkis*, 22 July 2019, p. 1464.

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9 *Witness Statement of Alan Woodward*, para. 13.

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Glossary

The Commission notes that several of the terms within this glossary differ from phrasing used in its letters patent. Where this is the case, the Commission has either made a deliberate choice to provide greater clarity on a term, or to enable a more inclusive interpretation. The Commission has inquired into all matters as per the expectations set in the letters patent.

Aboriginal community controlled health organisation
A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health services to the community that controls it, through a locally elected board of management. This definition is consistent with that stated by the National Aboriginal Community Controlled Health Organisation.[1]

Aboriginal people
We recognise the diversity of Aboriginal people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we have used the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.[2]

Activity-based funding
While similar to a fee-for-service funding model, an activity-based funding model distributes funding to providers for the number of times they provide services to a person, with the amount based on each person's individual needs.[3]

Acute mental health inpatient services
Acute mental health beds, or acute inpatient units, support people experiencing an acute episode of mental illness that calls for treatment in hospital. These services include acute mental health beds for young people, adults and older adults.

Adult and Older Adult Area Mental Health and Wellbeing Services

Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 26 years or older in both community and bed based settings.

Adult and Older Adult Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services.

Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.

Adult and older adult community mental health and wellbeing system

Future system that will provide treatment, care and support to Victorians over the age of 26 years. The Commission has taken an expansive view of what makes up the community mental health and wellbeing system, beyond mental health and wellbeing services. The system can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Adult and Older Adult Local Mental Health and Wellbeing Services
- Adult and Older Adult Area Mental Health and Wellbeing Services
- statewide services.

Within this system, there will be an older adult mental health and wellbeing service stream that provides treatment, care and support for people with complex and compounding mental health needs generally related to ageing who are over the age of 65.

Adult and Older Adult Local Mental Health and Wellbeing Services

Future services that will deliver treatment, care and support to people aged 26 years or older. They will be delivered in a variety of settings where people first access services and receive most of their treatment, care and support. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions for community mental health and wellbeing services. Service delivery may involve Area Mental Health and Wellbeing Services.

Area Mental Health and Wellbeing Services

Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams in both community and bed based settings. Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them.

Services will be delivered through a partnership between a public health service and a non-government organisation that delivers wellbeing supports.

There will be separate Area Mental Health and Wellbeing Services for infants, children and young people and for adults and older adults. For infants, children and young people there will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services (0–11); and Youth Area Mental Health and Wellbeing Services (12–25). There will also be Adult and Older Adult Area Mental Health and Wellbeing Services (for people over the age of 26).

Area mental health services

The current state-funded area mental health services provide clinical community-based and inpatient care. Seventeen of Victoria's public health services operate area mental health services.

Note: For the purposes of clarity, the current system is referred to in lower case and elements of the new service system have been capitalised in this report.

Allied mental health service

A service delivered by a diverse workforce such as psychologists, social workers and occupational therapists, working in a range of public, private, community and primary care settings.

Ambulatory care

Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term also refers to care provided to patients of community-based (non-hospital) healthcare services.[4]

Assertive outreach	A term applying to a broad range of models of care delivered in different service contexts. Generally, assertive outreach recognises that some people may require services to be more proactive in engaging or following up with them. Traditionally, assertive outreach models have included low caseloads, a multidisciplinary team, availability outside business hours, team autonomy and psychiatrist input. A variety of assertive outreach models are now in operation in Australia and internationally.
Assessment Order	An order made under the *Mental Health Act 2014* (Vic) that authorises a person to be compulsorily examined by an authorised psychiatrist to determine whether the treatment criteria, specified in the Mental Health Act, apply to the person. The order can either be an Inpatient Assessment Order or a Community Assessment Order, which reflects the location of where the examination is to occur.[5]
Authorised psychiatrist	A psychiatrist appointed by a designated mental health service to exercise the functions, powers and duties conferred on this position under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or any other Act.[6]
Blended care	Providing care through integrating digital and face-to-face supports. In blended care, digital supports are used to complement face-to-face services and to build on the gains achieved in face-to-face delivery.[7]
Capitation funding	Under a capitation payment model, providers receive a fixed amount of funding for each person who registers with them for a specified period, usually a year.[8] Capitation funding is similar to block funding; however, the funding is based on the number and mix of people who are registered with the service.
Care	The provision of ongoing support, assistance or personal care to another person.[9]
Carer	A person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.[10]

Clinical governance	'[T]he systems and processes that health services need to have in place to be accountable to the community for ensuring that care is safe, effective, patient-centred and continuously improving'.[11]
Coercion	The action or practice of persuading in a way that uses or implies force and threats—forcing someone to do something.
Commissioning	While there is no single agreed definition, commissioning can be understood as a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement.[12] Co-commissioning or joint commissioning refers to the ways in which organisations work together and with their communities to make the best use of limited resources in the design and delivery of services and to improve outcomes.[13]
Community care unit	A unit that provides clinical care and rehabilitation services in a homelike environment.
Community health services and integrated care services	Services that provide primary health, human services and community-based supports to meet local community needs.
Community mental health and wellbeing services	Services provided outside a hospital setting—in community settings such as clinics or centres, in people's homes or other places, or delivered by phone or videoconferencing, or online.[14] Community mental health and wellbeing services delivered by hospitals are sometimes referred to as 'community ambulatory services' and include care delivered by hospitals, but not always in the hospital itself, such as through outpatient or day clinics.[15]

Community mental health and wellbeing services core functions

The core functions are recommended by the Commission to ensure consistency in treatment, care and support delivered across Victoria. The core functions, which are common across all age ranges, are:

- integrated treatment, care and support proportionate to consumers' needs, consisting of:
  - treatment and therapies—including a broad range of psychological and psychiatric therapies, other therapeutic interventions, support for physical health, and support for substance use or addiction
  - wellbeing supports—including supports for community connection and social wellbeing, building life skills, securing and maintaining housing, and education, training and employment supports
  - education, peer support and self-help—through education, peer self-help and guided self-help
  - care planning and coordination—to ensure that treatment, care and support is proportionate to needs and to provide continuity of care
- services to help people find and access treatment, care and support and in Area Mental Health and Wellbeing Services to respond 24 hours a day, seven days a week to people experiencing a mental health crisis
- support for primary and secondary services (for example, GPs), including primary and secondary consultation and comprehensive shared care.

Comorbidity

A situation where a person has two or more health problems at the same time. Also known as multimorbidity.

Compulsory patient

Under section 3 of the *Mental Health Act 2014* (Vic) a compulsory patient means a person who is subject to an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order under the Act. Compulsory patients are sometimes referred to as 'involuntary patients'.

Compulsory treatment	The treatment of a person for mental illness subject to an order under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or the *Sentencing Act 1991* (Vic). This can include the administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. Compulsory treatment is sometimes referred to as 'involuntary treatment'.
Consecutive order	When a person is placed on a new compulsory treatment order, in anticipation of the current order ending,[16] to create a continuous duration and includes an Assessment Order, a Temporary Treatment Order and a Treatment Order.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, have used mental health services and/or received treatment, care or support.
Consumer-completed measures and family-, carer- and supporter-completed measures	These measures collect information on the effectiveness of mental health and wellbeing services directly from the people who access services. They are a direct measure of experiences or outcomes, as determined by the individual. This information can be collected using a range of tools including questionnaires or standardised surveys.[17]
Consumer streams	The Commission uses the streams to describe how, at any given point in time, a person experiencing mental illness or psychological distress will need one of: • support from their communities and primary care services (communities and primary care stream) • treatment, care and support from primary and secondary mental health and related services (primary care with extra supports stream) • short-term treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (short-term treatment, care and support stream) • ongoing treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing treatment, care and support stream) • ongoing intensive treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing intensive treatment, care and support stream).

Co-production	This involves people with lived experience of mental illness or psychological distress leading or partnering across all aspects of an initiative or program from the outset—that is, co-planning, co-designing, co-delivering and co-evaluating.[18]
Cultural safety	An environment that is safe for people—where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.
Culturally appropriate	'An approach to policy, intervention, service delivery and intergroup interaction that is based on the positive acceptance of the cultural values and expectations of Aboriginal people.'[19] Culturally appropriate care is important for people from a broad range of cultures.
Culturally diverse	Term used in this report to reflect the fact that the Victorian population is diverse and that culture and language can influence people's needs and their access to mental health services that meet their needs.
Designated mental health service	A health service[20] that is prescribed in the Mental Health Regulations 2014 (Vic) to provide compulsory treatment[21] (includes Forensicare).
Digital mental health technology	The use of online and other digital technologies to improve mental health and wellbeing, including access to information, service delivery, education, promotion and prevention. It encompasses a vast range of technologies including apps, portals, social media, smartphones, augmented or virtual reality, wearables, activity tracking, e-referral, notifications and artificial intelligence. Other common terminology includes 'e-mental health' (health services that are online), 'm-health' (mobile and app-based support) and 'virtual health'.[22] This report uses 'digital mental health technology' as an overarching term that encompasses many types of technology. Where relevant, however, the report names specific technologies.

Discrimination	At its most basic, discrimination refers to the prejudicial treatment of people based on their individual or collective characteristics. In Victoria, the *Equal Opportunity Act 2010* (Vic) makes it unlawful to discriminate on the basis of 'disability' (which is defined to include a 'mental or psychological disease or disorder')[23] in certain settings including health care, employment and schools. This can be through 'direct discrimination' such as when someone is treated unfavourably because of a personal characteristic like mental illness.[24] This could be a refusal to treat someone, provide them access to services or admit them to a school because they have a mental health diagnosis. The law also protects against 'indirect discrimination', where an unreasonable requirement, condition or practice disadvantages a person or group of people based on a characteristic.[25]
Dual diagnosis service	Term historically used to describe services in Victoria that provide treatment, care and support to consumers living with mental illness and substance use or addition.
Dual disability	Term defined in the Commission's interim report as people living with both mental illness and an acquired or neurodevelopmental disability (such an intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder or a communication disorder).[26]
Early intervention	Includes prevention and early treatment. Early intervention can involve equipping people to deal with the signs and symptoms of illness or distress and helping people as soon as possible once mental distress is identified in order to improve the prospect of recovery (for example, following exposure to trauma).
Electroconvulsive treatment	The 'application of electric current to specific areas of a person's head to produce a generalised seizure'.[27] Also known as electroconvulsive therapy.
Enrolment	Refers to a consumer voluntarily enrolling with a service provider who is responsible for coordinating their comprehensive care. The consumer is free to get care through this 'responsible' provider, or through alternative providers. Enrolment may or may not be associated with a 'capitated' payment that is linked to the number of consumers enrolled (refer to definition: 'Capitation funding').
Family	May refer to family of origin and/or family of choice.

Fee for service Under a fee-for-service funding model, service providers receive funding based on the number and mix of procedures, treatments and services they deliver.[28]

Forensic mental health service A service that provides treatment, care and support services to people living with mental illness who have come into contact with the criminal justice system.

Forensic patient A person under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) through an order of a court and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[29]

Good mental health A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.

Harm minimisation A health policy approach that recognises there are complex and interrelated health, social and economic consequences of substance use or addiction that affect individuals, families and the community. A harm minimisation approach recognises that drug use is individual and occurs from occasional use to dependency. The approach does not condone drug use but recognises a range of strategies are required to support a progressive reduction in substance-related harm.

A harm minimisation approach is based on three pillars:

- Harm reduction aims to reduce high-risk behaviours associated with substance use and providing safer settings such as smoke-free areas or free water at music festivals.
- Demand reduction is about preventing uptake of substances. Demand reduction also involves helping people who use substances to recover through a range of evidence-based care, treatment and support options.
- Supply reduction is about controlling the supply and availability of substances.

Indicators	Qualitative or quantitative measures that can help determine change or progress and can be used to determine whether short-, medium- or long-term outcomes are being achieved. When indicators are used to measure the outcomes of a particular program or intervention (for example, resulting from reforms) they are measured from a baseline (before the program or intervention), at regular intervals after the intervention starts, and at the end.[30]
Infant, Child and Family Health and Wellbeing Hubs	Future local mental health and wellbeing services for people aged 0–11 years that will take the form of Infant, Child and Family Health and Wellbeing Hubs. These hubs will take a one-stop shop approach to child health by prioritising infants and children with emotional (for example, mental health challenges), developmental (for example, intellectual disability, autism spectrum disorder, speech delay) and physical health challenges (for example, asthma, allergies, chronic disease) that have continued to affect their wellbeing despite previous support. The hubs will provide age-appropriate treatment, care and support, use a whole-of-family approach, conduct a range of assessments as needed and be supported by Infant, Child and Family Area Mental Health and Wellbeing Services.
Infant, Child and Family Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–11 years. Infant, Child and Family Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. These services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

Infant, child and family mental health and wellbeing service stream

Future service stream that will provide treatment, care and support to Victorians under the age of 12 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system.

The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Infant, Child and Family Local Health and Wellbeing Services
- Infant, Child and Family Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services
- statewide services.

Infant, Child and Youth Area Mental Health and Wellbeing Services

Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–25 years in both community and bed based settings.

The 13 Infant, Child and Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services.

Within these services will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services.

Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.

Infant, child and youth mental health and wellbeing system	Future health system that will provide treatment, care and support to Victorians aged 0–25 years. Within this broad system, there are two service streams—the infant, child and family mental health and wellbeing service stream for people aged 0–11 years and the youth mental health and wellbeing service stream for people aged 12–25 years. At the area level, there will be shared clinical governance across the age range of 0–25 years through the 13 Infant, Child and Youth Area Mental Health Services.
Information collection, use and sharing	'Information collection' refers to mental health information a service provider or entity may collect as part of its organisational functions. 'Use' refers to the use of information for the purpose of delivering services to consumers, or for directly related purposes, such as administration. 'Use' also refers to who can see and use this information, and in what circumstances. It includes the protections and securities put in place to ensure privacy standards are met. 'Information sharing' broadly refers to the disclosure of information to another worker, provider, organisation or person for the purposes of treatment, support or accountability.
Inpatient	Relating to an admission to an inpatient unit of a designated mental health service.
Integrated care service	A service that provides a range of services and supports, including primary care and mental health care.
Intersectionality	Drawing on the Victorian Government's 2019 *Everybody Matters: Inclusion and Equity Statement*, the Commission describes intersectionality as a theoretical approach that understands the interconnected nature of social categorisations—such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age—which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group.[31]
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.

Lived experience workforces	A broad term to represent two distinct professional groups in roles focused on their lived expertise—people with personal lived experience of mental illness ('consumers') and families and carers with lived experience of supporting a family member or friend who has experienced or is experiencing mental illness. Within each professional discipline there are various paid roles, among them workers who provide support directly to consumers, families and carers through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.
Local Mental Health and Wellbeing Services	Future services that will provide treatment, care and support in a variety of settings where people first access services. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions. Service delivery may occur in partnership with area services. These services will be a combination of primary and secondary responses supported by some tertiary-level responses. There will be separate local services for each of three age groups: Infant, Child and Family Local Health and Wellbeing Services (0–11), Youth Local Mental Health and Wellbeing Services (12–25) and Adult and Older Adult Local Mental Health and Wellbeing Services (over 26).
Medicare-subsidised mental health-specific service	Service in which the Medicare Benefits Scheme and the associated Better Access Initiative provide subsidised access to GPs and other health professionals such as psychiatrists, psychologists and other allied health practitioners.
Mental health and wellbeing	An optimal state of mental health, including as it relates to people with lived experience of mental illness or psychological distress. It can also be used to refer to the prevention, avoidance or absence of mental illness or psychological distress.

Mental Health and Wellbeing Commission	A new independent statutory authority recommended by the Royal Commission to: • hold government to account for the performance and quality and safety of the mental health and wellbeing system • support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system • monitor the Victorian Government's progress in implementing the Royal Commission's recommendations • address stigma related to mental health.
Mental health and wellbeing information	Information or an opinion about a consumer's physical, mental or psychological health, a health service provided, a consumer's expressed wishes about future service delivery, and personal information collected to provide health services. Information from others, including families, carers and supporters may also be included in mental health information, where appropriate.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental health system	Overarching term that takes in services (with various funders and providers) that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers. This term is used to describe the current and historical system.
Mental Health Tribunal	Independent statutory tribunal established under the *Mental Health Act 2014* (Vic) to hear and determine the making of Treatment Orders and other applications, including applications to perform electroconvulsive treatment when a person does not have decision-making capacity or is under the age of 18 years and applications to perform neurosurgery for mental illness.[32]

Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.[33] The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Mental wellbeing	A dynamic state of complete physical, mental, social and spiritual wellbeing in which a person can develop to their potential, cope with the normal stresses of life, work productively and creatively, build strong and positive relationships with others and contribute to their community.
Neurosurgery for mental illness	Any of the following three procedures, provided to treat a person meeting the criteria for mental illness: a) 'any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions for the purpose of treatment b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions for the purpose of treatment c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of treatment'.[34]
Nominated person	The formal nomination of a person under the *Mental Health Act 2014* (Vic) by a person to provide them with support and help and to represent their interests and rights at times when they are at risk of receiving compulsory treatment or are receiving compulsory treatment. The nominated person also receives information from the authorised psychiatrist at certain points and is consulted as part of decision-making processes under the Act.[35]

Older adult mental health and wellbeing service stream	Future service stream that will provide treatment, care and support to Victorians with mental health support needs generally related to ageing. It is a service stream within the broader adult and older adult mental health and wellbeing system. The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Adult and Older Adult Local Mental Health and Wellbeing Services • Adult and Older Adult Area Mental Health and Wellbeing Services, which will include older adult mental health and wellbeing specialist multidisciplinary teams • statewide services.
Outcome domains	Categories or groups of outcomes relating to broad areas of mental health and wellbeing. For example, outcome domains could relate to providing safe and high-quality mental health services or could relate to consumer satisfaction with service delivery and treatment and care.
Outcomes	Changes to the health or wellbeing of a person, group or population that results from some kind of intervention or multiple interventions. Interventions are defined very broadly and include particular models of care or treatment or making health services more accessible or acceptable to consumers.[36] Individual health outcomes are measures of individual health and wellbeing status. These can be measured in the short, medium and long term. Population-level outcomes are measures of aggregated data on the health of a population—for example, the population of Victoria or Australia.[37] Outcomes are measured using indicators.
Output funding model	The Victorian Government uses an 'output funding model' whereby departments use the investment allocated in the budget process to deliver on the government's objectives[38] and outputs.[39] Output performance measures are used to specify the expected performance standard at which these services are to be delivered,[40] covering measures such as the quantity of services provided, timeliness, quality and cost.[41]

Postvention bereavement support	A range of support services provided to people who have been bereaved by suicide.
Prevention and recovery care unit	Generally a short-term service (up to 28 days) that provides recovery-focused treatment in a community-based residential setting.
Primary care	Health services where consumers access care, treatment and support without the need for a referral or without needing to meet certain eligibility criteria. Primary care settings include general practices, community health services and some allied health services. Primary care services are widely distributed, are the most accessible form of health care and are provided in most local communities across Victoria. Typical primary care providers are GPs or allied health professionals such as social workers or mental health nurses. However, primary care can be offered by a wide range of professionals including psychologists, paediatricians and maternal child and health workers.
Primary consultation	A consultation between a mental health clinician or multidisciplinary mental health team and a consumer that may be conducted in person or through teleconferencing or phone. A primary consultation can occur following a referral—for example, where a GP makes a referral for a consumer to have a primary consultation with a psychiatrist.
Primary Health Networks	Networks that commission a variety of mental health, alcohol and drug, and suicide prevention services. Services commissioned can vary but may include: referral and support services; primary and specialist consultation services; prevention and early intervention services; services to reduce the harm associated with alcohol and other drugs; and capacity-building activities such as workforce education and training.[42] Refer to Box 29.4 in Chapter 29: *Encouraging partnerships* for detail.
Primary prevention	Strategies that aim to stop the onset of a health condition or disease from ever occurring by addressing the underlying causes or determinants of that condition. Primary prevention is distinct from secondary prevention, also referred to as early intervention, which aims to minimise the progress of a condition or disease at an early stage. It is also distinct from tertiary prevention, which aims to stop further progression of the condition and address the impacts that have already occurred.

Private hospital	Includes acute care and psychiatric hospitals, as well as private freestanding hospitals that provide day-only services.
Professional practice supervision	Refers to a formal professional relationship between two mental health practitioners that is designed to enable reflective practice, support professional self-care, maintain standards of professional practice, refine relational and clinical competencies and explore ethical issues. It is distinct from line management and performance management and is not a form of therapy.
Psychiatric assessment and planning unit	A unit that offers assessment and treatment for people experiencing an acute episode of mental illness and that minimises the need for an extended hospital stay in an inpatient unit.
Psychological distress	'One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness.'[43] This is consistent with the definition accepted by the National Mental Health Commission.
Public specialist mental health services	Services that provide both clinical and non-clinical mental health services. These are largely delivered by area mental health services operated by 17 public health services in Victoria.
Quality assurance	A range of strategies, including regulation, used to provide assurance that services are meeting minimum quality or safety standards and expectations.
Quality and safety oversight	Monitoring either system or service performance to identify and report on the quality and safety of mental health treatment, care and support. This can include oversight of specific practices (such as monitoring the use of electroconvulsive treatment), of the performance of an individual service, or of the whole system. Oversight often involves a degree of independence from the practice or service that is subject to oversight.
Recovery-oriented practice	Practice that supports people to autonomously build and maintain a self-defined, meaningful and satisfying life and personal identity, whether or not there are ongoing symptoms of mental illness.[44]

Reflective practice

Interprofessional and collaborative group-directed processes of learning through and from experience to gain new insights via:

- reflection on experiences of delivering care, treatment and support to consumers, families, carers and supporters
- examining and critically reflecting on assumptions underlying everyday practices
- reflecting on challenging interpersonal dynamics.

Regional Mental Health and Wellbeing Boards

Skills-based boards (rather than a representative board) recommended by the Commission that will include people with lived experience.

Regional Boards will seek to support communities to achieve the highest attainable standard of mental health and wellbeing through achieving the following objectives:

- Services respond to the needs of local communities.
- Services respond to individual needs and preferences, with a focus on community-based service provision.
- Services are integrated.
- Safe services are incentivised.
- Resources are allocated to improve outcomes.
- Resources are allocated in a way that maximises value.

Regional Boards will have a range of responsibilities. This includes being responsible for understanding need and planning services, supporting collaboration, funding and monitoring service providers, workforce planning and engaging with communities.

Regional Multiagency Panels

New coordinating structures recommended by the Commission in each region to bring together different service providers to support collaboration and accountability in providing services to consumers by multiple service agencies.

Restrictive interventions

May include 'bodily restraint', which is defined as a form of physical or mechanical restraint that prevents a person from having free movement of their limbs (excluding the use of furniture), or 'seclusion', which is the sole confinement of a person to a room or any other enclosed space from where the person is not free to leave.[45]

Seclusion and restraint	The *Mental Health Act 2014* (Vic) currently defines two forms of 'restrictive interventions': • **Bodily restraint** is a form of **physical** or **mechanical** restraint that prevents a person having free movement of their arms or limbs but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.[46] • **Seclusion** is the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.[47] Under the Act, seclusion and restraint can only be used in designated mental health services.[48] The Act also prescribes that restrictive interventions (including seclusion and restraint) may only be used after 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[49] Restrictive interventions can also be called 'restrictive practices'. This term is used throughout the report when necessary to reflect the use of the term in source data or evidence.
Secondary care	Health services that require a referral from a primary care provider (usually a GP). A common example is a referral from a GP to a private psychologist under the Better Access scheme. Another common form of secondary care is where a GP refers a consumer to a psychiatrist for a mental health assessment.
Secondary consultation	A discussion between mental health clinicians about a particular consumer. This can enable different care providers to work collaboratively to discuss issues with the consumer's care. Other models of secondary consultation focus on the needs of consumers more generally—for example, consumers with particular mental health needs or a specific diagnosis. This model focuses on sharing knowledge and expertise between different care providers.
Secure extended care unit	A unit offering secure services on a general hospital site for people who need a high level of secure and intensive clinical treatment for severe mental illness.

Security patient	A prisoner who is placed on an order under the *Mental Health Act 2014* (Vic) or the *Sentencing Act 1991* (Vic) and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[50]
Self-determination	In a collective sense, this term is used to refer to the 'ability of Aboriginal peoples to freely determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage'.[51] Some materials referenced by the Commission also use the term 'self-determination' to refer to individual autonomy and each person's ability to make choices about themselves and their life.
Service and capital plan	A plan that 'identifies present and, as best as possible, future demand for services' and is intended to 'guide the future allocation of resources'.[52] Also called a 'service and infrastructure plan'.
Service standards	The Commission has developed service standards to assist the Victorian Government and Regional Mental Health and Wellbeing Boards to select service providers—including new providers, such as consumer-led providers—with adequate capacity and capability to deliver mental health services. Refer to Chapter 28: *Commissioning for responsive services* for detail.
Shared care	A structured approach between two or more health services that each take responsibility for particular aspects of a consumer's care. This responsibility may relate to the particular expertise of the health service. Shared care is supported by formal arrangements, including clear care pathways and clinical governance, and all health services involved share a joint and coordinated approach to the health and wellbeing of the consumer. Shared care approaches can also benefit health providers—for example, by providing them with access to expert advice, which can increase their capabilities over time.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Social determinants of mental health	A person's mental health and many common mental illnesses are shaped by social, economic, and physical environments, often termed the 'social determinants of mental health'. Risk factors for many common mental illnesses are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.[53]
Social housing	Term covering two distinct forms of subsidised rental housing: public housing, which is owned and operated by the Victorian Government, and community housing, which is owned and operated by community housing providers.[54]
Statewide services	Based on the evidence presented, the Commission characterises statewide services as those that usually involve: • a workforce with a high level of expertise and knowledge • a dedicated research focus • the provision of treatment, care and support to a proportionately small number of people, often with higher levels of needs.
Stigma	The World Health Organization defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society'.[55] Stigma is a fundamentally social process—different characteristics or traits are not inherently negative, 'rather, through a complex social process, they become defined and treated as such'.[56] This process leads to social exclusion.[57]
Structural stigma	Refers to the 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatised populations'.[58]
Substance use or addiction	Substance use means the use of alcohol, tobacco or other drugs (prescription or illicit). Substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life or that of their family and broader social network. Addiction to substances means compulsive substance use that is outside a person's control, even when it has harmful effects on that person or their family.
Substituted decision making	Where a third party makes treatment decisions for the consumer.

Supported decision making	The process that supports a person to make and communicate decisions with respect to personal or legal matters. This may be achieved by offering consumers access to a variety of tools and resources such as non-legal advocates and peer workers.[59]
Systemic discrimination	Term that 'describes patterns or practices of discrimination that are the result of interrelated policies, practices and attitudes that are entrenched in organisations or in broader society'.[60]
Telehealth	Video teleconferencing using some form of online software or phone-conferencing to deliver services and supports directly to a consumer.[61]
Temporary Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by an authorised psychiatrist following an examination under an Assessment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Temporary Treatment Order or a Community Temporary Treatment Order.[62]
Tertiary care services	Highly specialised medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.
Treatment	When 'a person receives treatment for mental illness if things are done in the course of the exercise of professional skills to remedy the person's mental illness; or to alleviate the symptoms and reduce the ill effects of the person's mental illness'.[63]
Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known at 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.
Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by the Mental Health Tribunal following a period of treatment under a Temporary Treatment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Treatment Order or a Community Treatment Order.[64]

Value-based care	Care whose goal is to create more value for consumers by focusing on the outcomes that matter to them, rather than just focusing on cost-efficiency. Some funding approaches are designed to encourage greater value, such as bundled payments.[65]
Voluntary patient	A person who receives treatment for a mental illness or psychological distress who is not subject to a compulsory assessment or treatment order.
Wellbeing supports	Used to describe supports for wellbeing in the future system. Includes supports currently known as 'psychosocial supports'.
Whole of government	Although there is no universally agreed definition of 'whole-of-government' approaches (often interchangeably referred to as 'joined-up' approaches), the Commission uses this phrase to denote different areas of government (for example, health, human services, justice and corrections) working together to achieve shared outcomes.[66]
Whole of system	The Commission's terms of reference define the mental health system by reference to mental health services that are funded wholly, or in part, by the Victorian Government. When the Commission refers to 'whole of system' in relation to the mental health system, the reference is to a broader system. This includes not only public sector bodies and organisations at the federal, state and local government levels; it includes all people and organisations who participate in—or are connected with—the new mental health and wellbeing system recommended by the Commission.
Youth Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 12–25 years. Youth Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

Youth Local Mental Health and Wellbeing Services

Future services that will deliver treatment, care and support to people aged 12–25 years or older.

The role of Youth Local Mental Health and Wellbeing Services in the youth mental health and wellbeing service stream will be predominantly played by the network of headspaces across Victoria, although, over time, other providers may also choose to deliver this level of service.

Youth Local Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services will be formally networked within each of the 13 areas. They will work together in partnerships to provide treatment, care and support to young people.

Youth mental health and wellbeing service stream

Future service stream that will provide treatment, care and support to Victorians aged 12–25 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system.

The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Youth Local Mental Health and Wellbeing Services
- Youth Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services
- statewide services.

Shortened forms

The following shortened forms are frequently used in this report. Other shortened forms are explained where they are used.

AC	Companion of the Order of Australia
AM	Member of the Order of Australia
AO	Officer of the Order of Australia
CEO	Chief Executive Officer
DNA	deoxyribonucleic acid
GP	general practitioner
IT	information technology
LGBTIQ+	lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning
MP	Member of Parliament
OAM	Medal of the Order of Australia
PSM	Public Service Medal
TAFE	Technical and Further Education

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