StarHealth

First for your Health & Wellbeing

Submission to the Royal Commission into Victoria's Mental Health System

July 2019

RE: Submission to the Royal Commission into Victoria's Mental Health System

Dear Commissioners,

Thank you for the opportunity to provide a submission to the Royal Commission into Victoria's Mental Health System. Star Health believes this is an unprecedented opportunity to reshape the mental health system to better meet the needs of Victorian consumers and carers.

Star Health is a major provider of primary health and community services across the inner and middle south of Melbourne. We offer a variety of services including in the areas of: mental health, alcohol and other drugs, GP, dental, allied health, Indigenous health, homelessness and family violence.

Star Health has a strong focus on social justice, and specialist expertise in engaging high risk and hard to reach populations. We also engage in community building and health promotion activities to build the health and wellbeing of our local communities.

Please find attached our submission to the Royal Commission, which has been developed in consultation with our mental health staff and consumers.

If any aspect of this submission requires clarification please contact me at the Star Health office on (03) 9525 1300.

Yours sincerely,

Damian Ferrie
Chief Executive Officer

Star Health

Introduction

Star Health is one of the state-wide network of community health services registered under the *Health Services Act (1988).* This network of community health providers covering the entire state deliver a comprehensive range of health programs in partnership with local communities. Community health services such as Star Health are a key part of the health system and represent an underutilised and often unconsidered resource to better meet the needs of Victorians with mental ill health.

Community health services offer an opportunity for one-stop-shop approaches to wellbeing that allow service delivery in a destigmatised community environment. Community health services are skilled in the delivery of services from prevention and health promotion through primary care, allied health, chronic condition management, alcohol and other drug treatment and community mental health support. In its consideration of system design the Commission should consider community health service infrastructure as a key resource in reorienting the mental health system to localised community-based services.

In this context, Star Health has been a major provider of the well-established community mental health programs including Victorian Mental Health Community Support Services (MHCSS), and the Commonwealth Personal Helpers and Mentors Service (PHaMs). Star Health has seen that the flexibility of these programs to address individual consumer needs have led to many positive outcomes for our consumers. It has also enabled us to develop and foster a highly skilled and dedicated community mental health workforce.

The introduction of the National Disability Insurance Scheme (NDIS) has been accompanied by the cessation of these programs. It is understood that only approximately 10% of people living with a severe mental illness will be eligible for the NDIS.[1] Whilst there are some smaller or time-limited programs recently released by the Commonwealth and State in efforts to at least partially fill the resultant gap in the system, the total quantum of funding and more narrow eligibility requirements of these programs mean that far fewer consumers can access these services (and the NDIS) than before.

Star Health remains committed to supporting the National Disability Insurance Agency (NDIA) and partners to optimise psychosocial supports through the NDIS.[2] At the same time, we also urge the Commission to consider other ways to leverage existing skills, knowledge and connections of community health providers such as Star Health, to ensure that this "missing middle" – those who are not "sick enough"[3] to access the NDIS or acute mental health services, but who need support to ensure they don't end up needing longer-term or acute services – are not further left behind.[4]

[1] Hancock, N, Bresnan, A, Smith-Merry, J, Gilroy, J, Yen, I Llewellyn, G 2018. *NDIS and Psychosocial disability – the Victorian Story: Insights and Policy Recommendations from Expert Stakeholders*, <http://sydney.edu.au/health-sciences/cdrp/publications/technical-reports/NDIS-and-Psychosocial-Disability_TheVICTORIANStory_March2018.pdf>

[2] Mental Health Australia 2018, *Optimising Psychosocial Supports Project Report*, <https://mhaustralia.org/optimising-support-for-psychosocial-disability>

[3] Olasji, M., Maude, P., & McCauley, K., 2017, 'Not Sick Enough: Experience of carers of people with mental health illness negotiating care for their relatives with mental health services', *Journal of Psychiatric and Mental Health Nursing,* vol.24, no.6, pp.403-411

[4] Perkins, M 2019, ''Nothing between GP and emergency': Victoria's mental health failure', *The Age*, 26 March, <https://www.theage.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html>

Star Health's submission

Star Health considers the following as key foundational elements for a reimagined Victorian Mental Health System:

- **Social determinants of health** – According to the World Health Organisation, addressing the social determinants of health is crucial to improving mental health, and reducing the risk of mental ill health that is associated with social inequality.[5]
- **Consumer, carer and family-inclusive approach** – The key to a successful mental health system overall is one that is primarily situated within community, not specialist clinics or hospitals. This means that the entire system must be designed with a consumer, carer and family-inclusive approach. This should include providing support to carers and families within the integrated response to the consumer rather than separately. All mental health services should have carer support services such as counselling, peer support and respite brokerage.
- **Inclusive of priority population groups** – A reimagined system should be flexible enough to be able to tailored to meet the diverse needs of priority population groups, such as Aboriginal & Torres Strait Islander people, Culturally & Linguistically Diverse (CALD) populations and LGBTIQ people.
- **Reorient Mental Health Care** – Mental health services need to be focused on local, community-based delivery and function as accessible, comprehensive hubs connected to local service systems. They need to allow early intervention and extended-hour access to reduce reliance on Emergency Departments as the system entry point. To achieve an integrated mental health service system, we must remove the artificial barrier between clinical and community services.
- **Skilled workforce** – It is clear that we need to attract and retain qualified mental health professionals within all areas of the mental health system, including the community. We must ensure qualified and experienced staff are available in all parts of the system, especially where they can prevent escalation to acute services. Models such as Assertive Community Teams provide a model for embedding skilled staff at the frontline of service delivery.

In addition, the following specific areas are presented to the Commission for further consideration, based on Star Health's experience and areas of expertise:

[5] World Health Organisation 2014, *Social Determinants of Mental Health,* <https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=2FE04F59C886736CB34C04C7446B1014?sequence=1>

1. Prevention – connected and resilient communities

Population level health promotion interventions to support local communities to build connections and resilience is an essential part of any population based mental health system to create a mentally healthy community, including to reduce stigma and discrimination. This is particularly in response to a growing body of evidence suggesting that the quality and quantity of social relationships affect physical and mental health, and have an impact on risk of mortality comparable with well-established risk factors such as smoking and alcohol.[6,7,8]

Recognising and seeking to address social isolation and loneliness is crucial to keeping people well in the community, and minimising potential further development of mental ill health. Local councils and community health services are well placed to roll out such initiatives which must be locally based and delivered in partnership with local communities.

> *"Community Health has made a difference to my life because it realises that my health is not separate from my connection to people in my local community. It has connected me with other people that have continued to help me overcome barriers in my life."*
>
> – Star Health consumer

Examples of existing initiatives which could be built on or inform the development of other models include:

- South Melbourne Community Capacity Building Initiative – a new partnership between the Department of Health & Human Services (DHHS) and Star Health piloting an integrated social landlord approach to improve outcomes for public housing residents using a trauma-informed community building approach.
- Social Health & Inclusion Port (SHIP) – an initiative of Star Health that brings together local residents and community organisations to improve the health and wellbeing of the Port Melbourne community. Social Connections is one of SHIP's four priority areas, and has provided a range of opportunities for Port Melbourne residents to connect, be active in their community and learn new skills.[9]
- Social Spoons – an initiative of Star Health providing consumers with a mental health condition with subsidised café meals at supportive and welcoming cafes, aiming to improve social connectedness. An evaluation of the pilot of this program demonstrated that members felt more connected to the community as a result of their involvement in the program.[10]

  > *"It helped me a lot, as I could be more social, a reason to get out of the house, options for healthy meals and stopped me from going to drop in centres."*
  > *"[It has] enabled me to afford to socialise and meet people."*
  >
  > – Social Spoons participants

That the Commission consider:

Expanding or creating initiatives that build connections and resilience in the community – including to address social isolation and loneliness, and reduce stigma and discrimination

[6] Public Health England 2015, *Local action on health inequalities: reducing social isolation*, <https://www.gov.uk/government/publications/local-action-on-health-inequalities-reducing-social-isolation>
[7] J. Hol-Lunstad et al 2010, 'Social Relationships and Mortality Risk: A Meta-analytic Review', *PLOS Medicine*, <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000316>
[8] N. Leigh-Hunt et al 2017, 'An overview of systematic reviews on the public health consequences of social isolation and loneliness', *Public Health*, <https://www.publichealthjrnl.com/article/S0033-3506%2817%2930273-1/pdf>
[9] Social Health and Inclusion Port 2017, 'Port Melbourne: connected, healthy & inclusive', <http://www.shiportmelbourne.com.au/>
[10] Social Spoons 2012, 'Pilot Evaluation Report', <http://socialspoons.webgeneration.com.au/files/Pilot%20evaluation%20report%20June%202012.pdf>

2. Preventative self-care options

Currently, one of the few early intervention options for a person who is experiencing mental illness is to access psychological supports via a doctor (GP), and a mental health care plan, which requires a formal diagnosis. Whilst the 10 Medicare-subsidised psychological support sessions that this plan provides is adequate support for some people, for many others it is not enough.[11] This view is shared by the Medicare Benefits Schedule Review's Mental Health Reference Group, which reports that 10 sessions is not enough to improve outcomes for those experiencing moderate to severe mental illness.[12]

Victoria has a comprehensive system of community health services which offer DHHS-funded individual and group counselling designed to intervene to support people through stressful life events and issues that are not yet at the threshold of a formal diagnosis. However, these services have been neglected and underfunded with no growth funding for many years. **There is a desperate need to address this gap in preventative self-care options and to expand community health counselling services**, inclusive of group and individual therapeutic interventions. The benefits of preventative self-care programs are described by Star Health group participants:

- Learning and sharing new skills:
  "I learn things like mindfulness, interpersonal skills, distress tolerance. It's like going through a washing machine and a dryer – its given me a fresh outlook!"
- Building social confidence and new relationships:
  "It's really helpful that you know the other people in the groups are struggling with their own challenges… it means you don't need to feel ashamed or embarrassed."

Alice's Story

I was 12 years old when I first wrote about suicide. My teachers got wind of this and I was diagnosed with depression and forced into regular counselling sessions. Unfortunately, nothing really improved and my sadness persisted. After my third serious suicide attempt at the age of 20, I was hospitalized for depression, anxiety and anorexia, as well as drug-induced schizophrenia - I was placed on medication for which I would continue to take throughout my life. All throughout my teens and twenties I engaged in various forms of treatment in the hope of some kind of shift in my thinking, feelings and behaviours. I experienced small shifts, but never anything significant, powerful, life changing or enduring.

Two years ago, I was provided with the opportunity to become part of the Personal Helpers and Mentors (PHaMs) Program at Star Health. At that time, I was unemployed, totally isolated and withdrawn, still experiencing the debilitating effects of anxiety and depression, had just started addressing my issues with drugs and alcohol, and still deep in the throes of my eating disorder. I had never had a full time job, had never been in a relationship and had no friends or social life. My life was muted, in black and white, on pause for the past 20 or so years.

Carolina, my case manager brought up the idea of attending a group run by Star Health. I had tremendous anxiety, and it took a while to talk myself into it. I still remember the first group I attended. For me it was a big deal that I was leaving the house, committing to something for 5 weeks, and that I was going to be around people I didn't know. I didn't really talk to anyone, or absorb the information being delivered, but I was getting out of the house and that was a huge deal. The group gave me a sense of purpose. Once the group was over, I decided to build on the momentum and enrolled in another group. Slowly but surely, my anxiety decreased and I was starting to have a voice. In time I would start participating in discussions, and as time went on I even engaged with people during breaks and after the groups. Participating in the groups made me feel more confident and like I had something worthwhile to contribute. I started seeing myself as someone who had value and my self-confidence grew.

I strongly believe in the power of groups and believe everyone can experience gains from participating. Whether it is simply getting out of the house, making a commitment to something, being around others or learning skills and mindsets for wellbeing. For me, the group programs at Star Health have been invaluable and I believe paramount in my recovery, and I will continue to take advantage of this resource, and urge others to do the same.

Alice is now a group co-facilitator in Star Health's Alive 2 Thrive Program.*

[11] Department of Health and Ageing 2010, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Initiative*, <https://www.health.gov.au/internet/main/publishing.nsf/Content/B273C016117297A6CA257BF0001DC545/$File/dat1.pdf>

[12] McCauley, D 2019, 'Bold recommendation for free 'preventative' psychology sessions', *Sydney Morning Herald*, 7 February, <https://www.smh.com.au/politics/federal/bold-recommendation-for-free-preventative-psychology-sessions-20190206-p50vzd.html>

That the Commission consider:

Expanding the provision of preventative self-care options (including those that don't require a formal diagnosis), such as individual and group counselling and psychosocial support

3. Identifying and addressing trauma

Our consumers and staff tell us that minimising, identifying and addressing trauma is crucial to improving overall mental health and wellbeing. Research indicates those who have experienced trauma in childhood are at a significantly higher risk of experiencing mental illness and poverty than those who have not.[13] This suggests that efforts to minimise trauma (especially childhood trauma) or seeking to address trauma may help to minimise mental illness in adulthood. This could involve exploring **workforce development initiatives to provide trauma-informed care** to people experiencing mental ill health. For example, Phoenix Australia's *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*[14] and the Blue Knot Foundation's (formerly Adults Surviving Child Abuse) *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Services Delivery*[15]could inform the development of such initiatives.

In this context, our consumers tell us that an incredibly important avenue that should be explored by the Royal Commission is a **mechanism for investigation and redress for trauma caused by the mental health system in the past**. Whilst this is not explicitly included in the terms of reference for this Royal Commission, it should be explored as a potential way to improve mental health outcomes (item 4 of the Royal Commission's Terms of Reference), and in response to the need to address stigma, and to ensure the participation of people with lived experience in decision-making that affects them (parts f and g of the recommendations of the Terms of Reference). Providing an avenue for investigation and redress will offer an opportunity for healing from which to move forward. This would also be consistent with other Royal Commissions which have included this in their terms of reference.

That the Commission consider:

Exploring approaches to support minimising, identifying and addressing trauma, such as workforce development initiatives and a mechanism for investigation and redress for trauma caused by the mental health system in the past

[13] Kezelman C & Stavropoulos P 2012. *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*, Blue Knot Foundation (formerly Adults Surviving Child Abuse), <https://www.blueknot.org.au/resources/Publications/Practice-Guidelines>
[14] Phoenix Australia 2013, *Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder*, <https://www.phoenixaustralia.org/resources/ptsd-guidelines/>
[15] Kezelman C & Stavropoulos P 2012. *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*, Blue Knot Foundation (formerly Adults Surviving Child Abuse), <https://www.blueknot.org.au/resources/Publications/Practice-Guidelines>

4. Community mental health models that offer consistent relationships and flexible responses

In addition to preventative self-care options, community mental health models that help consumers to stay well in the community, particularly as their needs change, should form a key part of the overall mental health system. Star Health can offer insights from our staff and consumers who have been engaged in successful recovery-focussed community mental health programs such as Mental Health Community Support Services (MHCSS), and Personal Helpers and Mentors Services (PHaMs), about the elements of such programs that have worked well for them, to inform the development of future community mental health models.

Our consumers have told us about the models of care that are most effective in supporting them to stay well over time. Two key elements were highlighted:

- **Consistent, trusting relationships with practitioners/workers** – finding the right "match" of practitioner/worker for the consumer is crucial, as is having the time to build a trusting relationship. In contrast, a lack of consistent relationship can lead to setbacks and anxiety.[16] Star Health consumers also tell us that it is important that the practitioner/worker also knows them when they are well:

  "She knows everything that's going on with me and can communicate it clearly if I'm not able to."

  – Star Health consumer

- **Flexible models that enable care to be tailored to consumers' needs**, including as these needs change over time, is also important. For example, Star Health's 2017 Consumer Insight Report describes that the role of a practitioner/worker may shift from an "emotional and dependent relationship to a more practical and pragmatic one, as the consumer gains independence and builds health supportive relationships with family and friends".[17]

One way to do this is a **case management** model. In mental health case management, case managers undertake assessment, monitoring, planning, advocacy and link the consumer with rehabilitation and support services[18]. Importantly, case management is delivered by mental health professionals in a flexible face to face centre-based and outreach model. These programs should be underpinned by the principles of recovery-oriented care, an evidence-based model developed by consumers that focuses on the consumer's agency and individual pathway to wellness.[19,20] Amy's story below demonstrates the of role case management, particularly with a consistent practitioner supporting her to access different services as her needs changed, in facilitating positive outcomes for consumers.

In addition, there is a need for more intensive approaches for those with the most severe mental illness. The well-researched and evidenced **Assertive Community Treatment Model** (ACT) is an international example that is consistent with the case management model and ensures a skilled, multidisciplinary approach that works intensively with the consumer experiencing severe mental ill health and their family within the community. Various research has established the effectiveness of ACT teams improving outcomes for people experiencing mental ill health, including greater stability in the community, reduced hospital admissions and improved quality of life.[21,22,23]

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[16] Biringer, E, Hartveit, B, Sundfor, B, Ruud, T & Borg, M 2017, 'Continuity of care as experienced by mental health service users - a qualitative study', *BMC Health Services Research,* vol.17, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5698968/>

[17] MAKE 2017, *Star Health Consumer Insight Report*

[18] Intagliata, J, 1982, 'Improving the quality of care for the chronically mentally disabled: The role of case management'. *Schizophrenia Bulletin*, vol.8, pp.655-674, <https://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-ref#r83)>

[19] Jacob, K 2015, 'Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care', *Indian Journal of Psychological Medicine*, vol.37, no.2, pp.117-119, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/>

[20] Smith-Merry, J, Mellifont, D, Guillespie, J, Salvador-Carulla, L 2017, *Recovery-oriented mental health models*, Sax Institute, <https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/395002/Recovery-oriented-community-mental-health-models-SAX-REPORT.pdf>

[21] Bond,G, Witheridge, T, Dincin, J, Wasmer D, Webb J & De Graaf-Kaser R 1990, 'Assertive community treatment for frequent users of psychiatric hospitals in a large city: A controlled study'. *American Journal of Community Psychology*, vol.18, pp.865-891. <https://www.ncbi.nlm.nih.gov/pubmed/2091459>

[22] Select Committee on Mental Health 2006, 'Chapter 9 – Mental Health Services in the Community', *A national approach to mental health – from crisis to community*, <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c09>

[23] A. Rosen & M. Teesson 2001, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, p. 732. , <https://www.ncbi.nlm.nih.gov/pubmed/11990883>

That the Commission consider:

Community-based models that facilitate consistent relationships, flexible responses, and are under-pinned by recovery-oriented principles, including case management and Assertive Community Treatment models

Amy's Story

Amy is a female, in her thirties who was born in Asia. She moved to Western Australia to pursue a relationship with a man she met online. Over the course of a year, the relationship became abusive, however Amy found the strength to leave her partner and moved to Melbourne in crisis. She left the relationship with no money or supports of any kind and arrived in Melbourne with only the clothes on her back. Amy had no known prior history of mental illness, however following her traumatic experience and isolation having moved to a new city, she began experiencing symptoms of Major Depression and complex Post Traumatic Stress Disorder including low mood, suicidal thoughts, flashbacks, and feelings of hopelessness. Due to her immigration/visa status, she was not eligible for any Centrelink or welfare benefits and she had no family or friends to support her. She was vulnerable, homeless and without any financial support.

Amy presented to Star Health's Mental Health Community Support Service after receiving a referral from a woman's crisis agency. At the time of referral she was experiencing suicidal ideation every day and it was clear that this was perpetuated by her lack of income, and instability in crisis accommodation which she felt helpless to change. Amy's Star Health Recovery Practitioner helped work together with Amy and women's housing services to find her more secure housing. She was linked in with a regular GP at Star Health who was instrumental as part of her care team and she was also linked in with Star Health's consultant psychiatrist, as well as area mental health services and together all services were able to help mitigate her acute mental health concerns. This care team helped Amy to manage the symptoms of her mental ill-health and as this improved she was able to focus on her psychosocial support goals and work toward practical endeavours to help get her life back on track.

Amy was able to source employment and obtained a job part time with a local retail store which provided her with a consistent source of income and began to ease her financial concerns. Amy was supported by her recovery practitioner to sustain her employment, whilst concurrently working on her resume to source more appropriate longer-term employment. Amy had also linked in with a legal service which helped to resolve her immigration issues. Amy's recovery practitioner was able to liaise with the legal service and provide supporting documentation which assisted with her visa application process. Amy was able to have her visa issues resolved and is now an Australian permanent resident. Although, Centrelink benefits are not required, Amy is aware that if there were to have a reduction in her work hours or become unemployed she could access special benefit allowance through Centrelink. She was supported to apply for charitable community donations (Queens fund, rotary, food banks, etc) which enabled her to travel to and from work, as well as feed herself, and set up her new home. Amy was also linked in with her local library and supported to apply for other jobs and study opportunities.

During this time, her mental health started to improve as she was feeling a sense of purpose and meaning in her life and had the means to maintain this. Amy was discharged from area mental health services as her level of acuity had decreased, however she continued to work with her community-based recovery practitioner at Star Health to complete her remaining recovery goals and maintain her level of functioning. As support continued, Amy was working substantive hours during the week and her mental health had significantly improved. Her final goal was to return to university and study to become a lawyer, and she was successful in being accepted into a well-known Melbourne university to commence study.

Amy no longer experienced any symptoms associated with her mental illness and felt able to manage these should she reexperience any concerns. She was independently engaging in the community and was aware of coping strategies and referral pathways should she experience any mental health concerns again. She agreed that she no longer needed the support of her Star Health worker and decided that she was able to function without the need for other services such as NDIS due to the amount of progress that she had made and sense of hopefulness towards the future.

Amy was at severe risk of harm and deterioration of her mental health, and one of the key contributors exacerbating her mental ill-health was her financial stress and lack of economic security. Holistic support for her mental health including assistance and guidance relieved some of the pressures surrounding her finances and enabled her to get back on track with her recovery and life's goals.

5. Joined-up care – co-location and partnerships between services

Community health services such as Star Health provide an ideal **one-stop-shop for providing joined-up care** to consumers in one location. Star Health's own data from 2017-2019 shows that over 1300 people accessed our mental health programs, and that at least half of these people also accessed on average a minimum of one other Star Health service (with 28% accessing two or more other Star Health services), predominantly across services including: physiotherapy, podiatry, alcohol and other drugs, dietetics, smoking cessation, occupational therapy and diabetes. A high percentage of mental health consumers also utilise Star Health's dental service as well due to the low cost of the service and their priority access afforded to mental health consumers.

This is consistent with feedback from our consumers who tell us that our staff are often able to identify that they may benefit from other services, and connect them in to other services:

> *"Community health means to me that I can access a service in one place for all my health needs. It provides a continuity and familiarity which is of pivotal importance particularly when one has reached Senior status. Star Health provides me with that service more than adequately."* – Star Health Consumer

However, community health services are an under-utilised resource in providing such comprehensive, integrated and destigmatised services to people living with or at risk of mental health issues, which could be better leveraged.[24]

In addition, our staff tell us that more needs to be done to facilitate **different practitioners and services working together in partnership**, including via mechanisms to improve information sharing and coordination of care. One example is the multi-agency working model in the United Kingdom, which "brings together practitioners from different sectors and professions to provide an integrated way of working to support children, young people and families."[25]

Other examples (below) are based on Star Health models where multi-disciplinary teams of staff are located in community settings that community members already access. This enables staff to build relationships with community members over time in a familiar environment, and then provide them with support and link them into other services that they may not otherwise access:

- Launch Housing – Star Health provides on-site community health nursing and occupational therapy services at Launch Housing's SouthBank crisis accommodation service, with a particular focus on unmanaged chronic health conditions, and on rebuilding people's confidence in healthcare providers.
- Bubup Womindjeka Family and Children's Centre – Star Health provides families with on-site access to child psychology, occupational therapy, physiotherapy and speech pathology services, to facilitate early intervention for vulnerable children and families.

Other examples that could be explored include the community-based mental health centres (MHC) in Trieste, Italy. MHCs provide multi-disciplinary teams of mental health workers at their centre, with support available 24 hours a day, 7 days a week. They provide overnight accommodation, have multi-purpose indoor and outdoor spaces, drop-in support and provide several avenues for both formal and informal engagement.[26]

The Commission should consider:

Mechanisms to support joined-up care, including better leveraging community health services and facilitating strengthened partnerships between different practitioners and services

[24] Victorian Auditor General's Office 2018, *Community Health Program,* https://www.audit.vic.gov.au/sites/default/files/2018-06/20180606-Community-Health_0.pdf

[25] Department for Education 2012, 'Multi-agency working', <https://webarchive.nationalarchives.gov.uk/20130104164035/https://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0069013/multi-agency-working>

[26] Select Committee on Mental Health 2006, 'Appendix 3 – Report of mental health services observed in Trieste, Italy', *A national approach to mental health – from crisis to community*, <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/e03>

6. Step up/step down and alternatives to Acute inpatient Care

Our consumers and staff have also told us about some effective supported step up/step down options, including as alternatives to inpatient care and hospital emergency departments, that should be expanded. This includes Prevention and Recovery Centres (PARC)[27], and Hospital Outreach Post-Suicidal Engagement (HOPE)[28]. These models are purpose-designed and improve continuity of care by providing additional support before and/or after a consumer spends time in an acute setting, smoothing the transition between settings.

In addition, integrated community-based care models that provide alternatives to hospital inpatient stays should be explored. There is strong evidence for example the Trieste Model as described above and home and day support models. Refer https://www.ncbi.nlm.nih.gov/pubmed/23165415 for evidence of using alternative options to acute care via step up/down community, day and home models.

That the Commission consider:

Expanding supported step up/step down options and community-based acute care, including as alternatives to ED – e.g. Prevention and Recovery Centres (PARC), Hospital Outreach Post-Suicidal Engagement (HOPE), and the Trieste model

7. Improved discharge planning

Another important aspect of continuity of care relates to **discharge planning and post-discharge support**. The importance of effective discharge processes in mental health care is highlighted by evidence which demonstrates that suicide risk is often the greatest after discharge from acute inpatient units.[29,30]

Consumers and staff also gave us feedback which suggests that the way discharge is managed can impact on their continuity of care, and ultimately overall health outcomes. They stressed the importance of ensuring that community mental health practitioners are involved in preparation for discharge from acute settings, and that family and carers are also involved in discharge planning, where possible. In addition, the Star Health's 2017 Consumer Insight Report provided suggestions to improve discharge (or end-of-engagement with a service):

- The ending would be a decision made by the consumer when they felt ready. Sometimes this would be a collaborative choice with the case manager, but never by the service independently.
- The service should phase out gradually, rather than having a clean stop, with plenty of warning that it was coming to an end.
- After leaving the service, consumers wanted to be able to link back in with their case manager for occasional check-ins, for navigation to other services when needed, or just in case something happened which meant they needed extra support.[31]

> *"I need to be able to reach back fast if I ever need help again"* – Star Health consumer

This approach to discharge, which could better be defined as moving between parts of an integrated system and scaling up and down service contact rather than a hard exit point, challenges the standard definition of discharge. There are some reports that this approach can also lead to fewer re-referrals.[32]

[27] Department of Health 2010, *Adult prevention and recovery care (PARC) services framework and operational guidelines,* <http://www.health.vic.gov.au/mentalhealthservices/parc.pdf>
[28] Department of Health & Human Services 2018, *Suicide Prevention in Victoria*, <https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria>
[29] Department of Health & Human Services 2018, *Suicide – discharge and follow-up of a person at risk,* <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/suicide-prevention-in-mental-health-services/suicide-discharge-and-follow-up-of-a-person-at-risk>
[30] Chung, D, Ryan, C, Hadzi-Pavlovic, D, Singh, S, Stanton, C & Large, M 2017, 'Suicide Rates After Discharge from Psychiatric Facilities', JAMA Psychiatry, vol.74, no.7, pp.694-702, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710249/>
[31] MAKE 2017, *Star Health Consumer Insight Report*, p.12
[32] Cheverton, F 2018, 'Closing Time: Reconsidering the Concept of Discharge in Child and Adolescent Mental Health Services', *Social Work Focus*, vol.3, no.1, p18, <https://www.aasw.asn.au/document/item/10507>

The Commission should consider:

Discharge processes that enable consumers to move between parts of a system and end an engagement on their own terms and gradually, enable post-discharge support, and ensure that relevant practitioners/workers and family and carers are involved where possible

8. Age-related gaps in the services

Consumers and staff also tell us that there are age-related gaps in services that need to be addressed to minimise other potential disruptions to continuity of care, including:

Youth Mental Health

- Many young people experiencing mental ill health may experience difficulty accessing appropriate support services, including headspace, for example if they have substance misuse issues or demonstrate suicidality.[33]
- The Victorian system of services for those with early psychosis or other severe mental illness is varied and inconsistent across the State with many areas lacking access to specialist dedicated clinic inpatient or community services.

Mental Health for Older Victorians

- There is an under investment in mental health and substance disorder services for Victorians over 65. It is difficult to access psychiatric assessment, intervention and support for people over the age of 65, when the need for these services do not stop at this age. Services without out of pocket expenses are particularly scarce.
- The age cut off for access to adult mental health services is arbitrary and should be removed. Transition to aged care services should be based upon consumer preference and presenting issues.
- The My Aged Care System which provides the framework for community aged care assessment and services does not adequately address the needs of those with mental ill health.

The Commission should consider:

Addressing gaps in the service system for young people and older Victorians including expanding youth mental health services, removing age cut offs in adult services and advocating for integration of mental health needs into My Aged Care

9. Integration of mental health and Alcohol and Other Drugs support

Many of our consumers simultaneously experience mental ill health and substance disorders, but are not always able to access suitable treatment for both issues. The AIHW reports that self-reported mental health conditions and levels of psychological distress are increasing among recent users of tobacco and illicit drugs, including that:

- Levels of psychological distress are higher among people who drink more than four standard drinks per day (16.1%) than those who do not (9.3%).
- Self-reported mental health conditions and levels of psychological distress significantly increased among recent users of cannabis, ecstasy, meth/amphetamines and cocaine between 2013 and 2016.[34]

People usually experience a complex relationship between mental health and alcohol and other drug use, with some people using drugs to provide relief for existing mental illness, and for others drug use may cause the onset of mental illness.[35] Despite this complex relationship and increasing prevalence of these co-occurring

[33] Doggett, J 2019, 'Why do we find it so hard to direct mental health spending to the people who need it the most?', *Inside Story*, 15 June, <https://insidestory.org.au/the-personal-and-the-political/>

[34] Australian Institute of Health and Welfare 2018, 'Alcohol, tobacco & other drugs in Australia', < https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions>

[35] ibid

conditions[36], we hear many stories of consumers not being able to access mental health services, including psychiatric services, when they also have a substance disorder.

Consumers and staff report that there is a lot of stigma surrounding substance disorders, with mental health practitioners preferring substance disorders to be addressed before mental health issues are broached. However, such a linear approach is not always appropriate or, importantly, a consumer's preferred course of action. For example, a consumer may want to tackle issues of past traumas via mental health support before seeking to address substance disorder issues.

Furthermore, there is evidence to suggest that treating mental health and substance disorders simultaneously leads to better outcomes for consumers, compared to treating these issues separately.[37,38] In addition, our staff tell us that consumers are more likely to engage with a service that enables them to tackle both issues (instead of being bounced between mental health and alcohol and other drug services) and that they have observed those with substance disorders benefit substantially from counselling support.

There are several mechanisms that the Commission could consider in facilitating the concurrent treatment of mental health and substance disorders:

- Seeking to address the stigma of substance disorders, particularly in the mental health sector
- Expanding dual diagnosis workforce/approaches across mental health and alcohol and other drug sectors
- Increasing the capacity of both mental health and alcohol and other drug workforces to be able to identify and simultaneously treat both issues, such as through facilitating skills and knowledge sharing and improved communication across both workforces
- Increasing access to psychiatrists without out of pocket expenses for consumers, particularly for those with substance disorders.

Models that could be considered in the development of an approach which encapsulates such changes includes the *Comprehensive continuous integrated system of care model*, which provides a model to organise services to individuals with co-occurring psychiatric and substance disorders. Its first underpinning principle is "dual diagnosis is an expectation, not an exception"[39]

Another model that could be considered is the *Integrated Dual Disorder Treatment model*, which combines substance disorder services with mental health services and "helps people address both disorders at the same time—in the same service organisation by the same team of treatment providers."[40]

That the Commission should consider:

Mechanisms to ensure both mental health and substance use disorder issues are treated equally and concurrently

[36] Select Committee on Mental Health 2006, 'Chapter 14 – Dual diagnosis 'The expectation not the exception'', *A national approach to mental health – from crisis to community*, <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c14>

[37] Kelly, T & Daley, D 2013, 'Integrated Treatment of Substance Use and Psychiatric Disorders', *Social Work Public Health*, vol.28, pp.388-406, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753025/>

[38] El-Guebaly 2004, 'Concurrent substance-related disorders and mental illness: the North American experience', World Psychiatry, vol.3, no.3, pp.182-187, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414708/>

[39] Minkoff, K 2005, *Comprehensive Continuous Integrated System of Care (CCISC)*, <http://ziapartners.com/wp-content/uploads/2011/04/CCISC-psychopharm.pdf>

[40] Center for Evidence-Based Practices 2011, 'Integrated Dual Disorder Treatment', <https://www.centerforebp.case.edu/practices/sami/iddt>

10. Experiences of LGBTIQ people, particularly trans, questioning and gender diverse people

There is a significant evidence that many people who identify as LGBTIQ experience poorer mental health outcomes than the non-LGBTIQ population.[41] For example, the 2016 National Drug Strategy Household Survey found that high or very high psychological distress was reported by more adults who identified as homosexual or bisexual (28%) or not sure/other sexual orientation (23%) than heterosexual adults (11%).[42]

In accessing mainstream health services, it is reported that many LGBTIQ people, particularly transgender, questioning and gender diverse people, still have poor experiences of the mental health system. This includes experiencing discrimination, refusal of service or inappropriate treatment (such as pathologisation of their LGBTIQ identity).[43] As with other areas of vulnerable populations, such as culturally and linguistically diverse communities, a combination of capacity building mainstream services and providing specialist LGBTIQ approaches is critical.

In this context, our consumers and staff told us that the following are important:

- Reducing stigma and discrimination, including pathologisation of LGBTIQ identity
- Building mental health organisational capacity by ensuring organisations have appropriate policies, procedures and training in place through processes such as Rainbow Tick accreditation
- Building mainstream and specialist LGBTIQ mental health community support services
- Consider having LGBTIQ health professionals as part of treatment teams.

Star Health is also a signatory of the joint statement by Thorne Harbour Health, Rainbow Health Victoria and Switchboard Victoria, which calls on the Commission to consider LGBTI mental health, and outlines six key areas for action. The joint statement, which is consistent with the themes in this section, can be found here: https://thorneharbour.org/news-events/news/leading-health-organisations-call-on-the-royal-commission-into-victorias-mental-health-system-to-consider-lgbti-mental-health/

That the Commission consider:

Mechanisms to improve the experiences of LGBTIQ people, particularly trans, questioning and gender diverse people, including to reduce stigma and discrimination, and build both mainstream and specialist organisational capacity

[41] LGBTI National Health Alliance 2013, *LGBTI People Mental Health & Suicide*, p.3, <https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2>
[42] Australian Institute of Health & Welfare 2018, '5.5 Lesbian, gay, bisexual, transgender and intersex people', Australia's health 2018, <https://www.aihw.gov.au/getmedia/61521da0-9892-44a5-85af-857b3eef25c1/aihw-aus-221-chapter-5-5.pdf.aspx>
[43] LGBTI National Health Alliance 2013, *LGBTI People Mental Health & Suicide*, pp.10-11, <https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2>

11. Addressing poverty and disadvantage associated with mental ill health

Star Health has extensive experience working with highly disadvantaged communities, with many of these people living in poverty. This includes people sleeping rough, homeless, transient or in insecure housing, or living in permanent rental (particularly private rental) where the rental cost leaves them in poverty. The reality is Australia's Newstart allowance of $555 a fortnight, and the Youth Allowance of $455 a fortnight creates poverty. For those fortunate enough to receive a disability support pension income of $843 a fortnight, poverty is less of an issue.

Our staff report that many of these community members experience significant mental ill health. The connection between poverty and mental illness is acknowledged by the World Health Organisation[44], as well as research that indicates that among the poorest one-fifth of Australians, 1 in 4 people have psychological distress at a high/very-high level, compared to about 1 in 20 people in the richest one-fifth of Australians.[45] Importantly, poverty can be a cause of, or a result of poor mental health.[46]

Due to the nature of their situations, many people face further challenges such as not being able to pay fines and accumulate debt, further compounding their disadvantage. There is often higher acuity need in those experiencing homelessness and other forms of disadvantage, which means they are frequently interacting with the justice system and accessing emergency departments and tertiary care.[47] The lack of supports, such as affordable and appropriate housing, lack of safe spaces and lack of flexible mental health responses available for these people means that the there is a significant number of homeless and unwell people moving around, which in turn has a major impact on the general community.

The impact for those with mental ill health caught up in poverty and homelessness is often that they end up in the justice system, either incarcerated or with burgeoning legal issues. There is an urgent need to support mechanisms within the Police and Justice systems to identify and divert those with serious mental illness into the mental health system, particularly through early diversion approaches. In addition, there is a need for legal and financial assistance to be imbedded within the mental health system.

That the Commission consider:

Mechanisms to identify early and divert those with serious mental illness from the Police and Justice system to the mental health system

The provision of legal and financial assistance within the mental health system

Star Health's experience is that many people experience such disadvantage and mental ill health that they find it difficult to independently seek or maintain access to services. This means that mechanisms such as **community outreach and assertive case management** are incredibly important in identifying, building relationships with and linking people into appropriate services and supports, including housing, mental health, alcohol and other drugs and harm minimisation services.

For example, as a provider of community outreach and assertive case management over many years, one of Star Health's key referrers has been local government parks and gardens teams. Members from these local government teams would identify people sleeping in public places such as on the foreshore or in gardens who

[44]World Health Organisation 2014, *Social Determinants of Mental Health,* retrieved 20 June 2019, p.8, <https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=2FE04F59C886736CB34C04C7446B1014?sequence=1> p.8

[45] Isaacs, A, Enticott, J, Meadows, G, Inder, B, 2018, 'Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas', *Front Psychiatry*, vol.9, p.536, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6213368/>

[46] Murali, V, & Oyebode, F 2004. 'Poverty, social inequality and mental health', *Advances in Psychiatric Treatment,* vol.10, no.3, pp.216-224, <https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/poverty-social-inequality-and-mental-health/39E6EB94B44818EDE417F181AC300DA4>

[47] Moore, G, Gerdtz, M, Manias, E 2007, 'Homelessness, health status and emergency department use: An integrated review of the literature', *Australasian Emergency Nursing Journal*, vol.10, pp.178-185, <http://harmreductionactioncenter.org/HRAC_DOCUMENTS/ACCESS%20TO%20HEALTHCARE/Homelessness_health_care-review_of_lit.pdf>

were distressed. They could call Star Health to seek the support of our community outreach teams, for people who otherwise may not be connected into services.

That the Commission consider:

Expanding the system capacity for assertive outreach to those disconnected from the system due to homelessness and other disadvantage

12. Access to safe, appropriate, affordable housing

Safe, appropriate, affordable housing is crucial to health and wellbeing, including mental wellbeing.[48] Housing First approaches recognise housing as a precondition for mental healthcare, and indeed, as a necessary component of that healthcare. There is evidence that when housed, people discharged from psychiatric hospitals require fewer days each year admitted to mental health units compared to the period before they were housed.[49,50]

More access to safe, appropriate, affordable housing, and range of housing options, is required to support people experiencing poverty and mental ill health. In the absence of appropriate housing for all, this should include **more crisis housing, more support for people in rooming houses, and supported accommodation for longer-term tenancies**.

Rooming houses are a common form of housing for people experiencing disadvantage. This includes those who are unemployed, have a disability, have a history of trauma, are socially isolated, and who are not connected to services.[51,52] Residents overwhelmingly report rooming houses to be dangerous and violent, dirty, and harmful to their mental health.[53] There is a need for more consistent monitoring of rooming house conditions, and more support (such as in-reach programs) for people in rooming houses.

Our staff tell us that many people who have spent a long time living on the streets struggle to maintain longer-term tenancies due to the significant adjustment and different skills and capabilities required. There is evidence that hospital admissions for mental health can be substantially reduced when housing is coupled with support, such as case management.[54] The provision of appropriate supportive housing can be expensive up front, but Star Health's experience as a mental health provider with nomination rights to about 35 housing units is that those clients who move to those units with continued support from our mental health team do stabilise and go on to live productive lives, reducing their need for service provision from Star Health and the broader service system. Many of them manage their health and wellbeing for many years without significant support from the system, but often remain connected in case of further episodes of mental ill health.

That the Commission consider:

More access to appropriate, affordable housing – including more crisis housing, more support for people in rooming houses and supported accommodation for longer-term tenancies

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[48] Lawson, J., Denham, T., Dodson, D., Flanagan, K., Jacobs, K., Martin, C., Van den Nouwelant, R., Pawson, H. and Troy, L. (2019) *Social housing as infrastructure: rationale, prioritisation and investment pathway*, AHURI Final Report No. 315, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/315, doi:10.18408/ahuri-5314001.

[49] Holmes, A, Carlisle, T, Vale, Z, Hatvani, G, Heagney, C, & Jones, S, 2017, 'Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness', *Australian Psychiatry*, vol.25, no.1, pp. 56-59.

[50] Parsell C, Petersen, M, Moutou, O, Lucio, E, & Dick, A, 2016, *Brisbane Common Ground Evaluation*, University of Queensland, <https://issr.uq.edu.au/brisbane-common-ground-evaluation>

[51] Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p 36, <https://www.ahuri.edu.au/__data/assets/pdf_file/0018/2196/AHURI_Final_Report_No210_The-experience-of-marginal-rental-housing-in-Australia.pdf>

[52] The Salvation Army Adult Services, 2011, 'No room to move? Report of the Outer West Rooming House Project', p.16

[53] Goodman, R., Nelson, A., Dalton, T., Cigdem, M., Gabriel, M. and Jacobs, K., 2013, *The experience of marginal rental housing in Australia*, AHURI Final Report No.210. Melbourne: Australian Housing and Urban Research Institute, p 25, <https://www.ahuri.edu.au/__data/assets/pdf_file/0018/2196/AHURI_Final_Report_No210_The-experience-of-marginal-rental-housing-in-Australia.pdf>

[54] Australian Housing and Urban Research Institute 2016, *What are the health, social and economic benefits of providing public housing and support to formerly homeless people?*, p.13, <https://www.ahuri.edu.au/research/final-reports/265>