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

July 2019

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Introduction

Melbourne City Mission (MCM) is a community service organisation that provides a range of supports to people who are experiencing different forms of disadvantage across Melbourne.

Our vision is to contribute to a fair and just community where people have equal access to opportunities and resources. We work alongside people and communities to provide long-term, sustainable pathways away from disadvantage.

MCM has more than 80 programs which span multiple service systems, including homelessness, disability, early childhood, health (home-based palliative care), justice, education and training, and employment services.

Mental health impacts many of our clients' lives and underpins much of our work – our programs are designed to engage people with complex mental health conditions and other vulnerabilities. MCM operates Frontyard Youth Services, an integrated youth services hub that supports young people at risk of or experiencing homelessness to find accommodation, as well as get access to mental health, wellbeing and social supports.

MCM welcomes the opportunity to contribute to the Royal Commission. The aim of this submission is to highlight the inequitable barriers that many of our clients face in accessing mental health supports, and to ensure that future reforms to Victoria's mental health system are designed around the needs of the people we support.

The information in this submission draws on client interviews, a client survey, staff consultation, case studies[1] prepared by staff, MCM research and administrative data. The submission addresses the below themes linked to the questions provided by the Royal Commission and ordered according to relevance to MCM's clients and services:

- Drivers of poorer mental health outcomes for the communities MCM supports (question 5)
- Barriers to accessing mental health treatment and support (question 4)
- Supporting people to get early treatment and support (question 2)
- Reducing the stigma of mental illness (question 1)
- Areas for reform for Victoria's mental health system (question 9)

Data snapshot

Many of the people that MCM support experience complex mental health and wellbeing issues, that intersect with their experiences of homelessness, disability, Alcohol and other Drug (AOD) issues, as well as structural and societal barriers including poverty, social exclusion and discrimination. Below is a snapshot of the mental health experiences of some of the main cohorts MCM works with, captured in 2018-19:

- 64% of clients who used MCM homelessness services had a mental health issue or concern identified by a worker.
- 44% of MCM homelessness clients self-reported having a prior mental illness diagnosis.

[1] The names and identifiable details of clients have been changed to protect their privacy.

- 48% of clients presenting at Frontyard self-reported having a mental health diagnosis. Frontyard supports around one third of the 6,000 people aged 12-25 who are experiencing homelessness in Victoria.
- 21% of clients who use MCM's disability services have a psychosocial disability (disability that arises from a mental health issue) or dual disability (co-presenting disability and mental health condition). Mental health issues of disability clients include anxiety, depression, schizophrenia and bipolar disorder.
- 67% of the young pregnant women and young mothers in the Cradle to Kinder[2] program had a prior or current mental health concern identified by a worker. Mental health concerns were the most cited issue in this program which provides intensive support to the most vulnerable young pregnant and parenting mothers in Victoria.
- 65% of students enrolled at the Hester Hornbrook Academy[3] were determined to require substantial and extensive adjustments to address 'social/emotional disability' and enable their access and participation in education.[4]
- The majority of MCM's clients are between the age of 12 and 25 years of age (67%).

Key findings

"*I was struggling every day, very sad feelings, never want to experience that life – being homeless and without my son ever again. Worst experience ever, even compared to being beaten. Hard not seeing my son. No control over my own life*." *(Client from MCM homelessness services)*

1. **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. Unsurprisingly, they have low levels of trust in the mental health system and lack the informal supports needed to navigate the complexities of the mental health and other services systems.
2. **Mental health services have failed to provide adequate supports that meet the needs of young people experiencing homelessness and people with overlapping and complex needs.** These young people are not able to engage with the available mainstream services designed for people with mild and moderate illness, and face significant structural barriers to accessing more intensive clinical mental health supports. Our clients are routinely excluded from clinical services for not meeting the right eligibility criteria, like not having a fixed address as a result of their homelessness. Mental health services often require the young person to 'fit' the service.
3. **Mental health, housing and disability systems fail to work together to develop solutions that address all aspects of a person's wellbeing.** The lack of coordinated services for people with overlapping mental health, disability and housing issues leaves many people without the

[2] Cradle to Kinder is a DHHS-funded intensive support program for the most vulnerable young pregnant and parenting mothers in Victoria.
[3] MCM's Hester Hornbrook Academy is an independent school that provides the Victorian Certificate in Applied Learning (VCAL) in a flexible learning environment.
[4] Data sourced for the Department of Education and Training's Nationally Consistent Collection of Data (NCCD) on School Students with Disability (NCCD). The category of social/emotional disability applied in the NCCD is defined as 'a disorder, illness or disease that affects the person's thought processes, perception of reality, emotions or judgement, or that results in disturbed behaviour.'

appropriate supports, and homelessness services are left to manage clients' complex mental health needs.

Key recommendations

MCM recommends that future reforms to Victoria's mental health system should consider:

1. The need for additional mental health services designed to support clients experiencing homelessness, dual disability, dual diagnosis and disadvantage more broadly, including:

1.1. Additional youth-focussed clinical mental health services that are designed to meet the needs of young people experiencing homelessness who are currently unable to access area mental health services. New services should be co-designed with young people, to ensure young people with the most complex needs are able to engage with clinical mental health supports (see page 13)

1.2. Additional general mental health and wellbeing services for young people experiencing homelessness and other complexities including trauma, AOD issues, disability that address whole-of-person wellbeing needs, as an alternative to current mainstream services which our clients struggle to engage with (see page 13)

1.3. Additional resources for a dedicated mental health crisis response service that works directly with homelessness services and other community service professionals who have assessed an acute and immediate response is needed for a young people person they are supporting (see page 24)

1.4. Support for mental health and community services that work with young people with complex mental health issues to have expanded operating hours, recognising that mental health episodes have a greater tendency to escalate to crisis point after traditional business hours (see page 24)

2. The need for better coordination and planning between the mental health, housing and disability systems to develop solutions for people with complex needs, including:

2.1. Better coordination and planning between the mental health, housing and disability systems to develop solutions for people with complex and overlapping needs, through building the mental health knowledge and skills of community sector professionals, embedding mental health clinicians in community services, and enabling the sharing of information on client mental health history when relevant (see page 16)

2.2. Specialist mental health support functions within the National Disability Insurance Scheme (NDIS) to support people with co-presenting disability and mental health issues and disability workers to navigate the interface between the mental health and disability systems (see page 16)

3. The need for increased investment in housing options for people with severe and persistent mental health issues, including:

3.1. Increased investment in housing options for people with complex mental health issues who don't have housing and who have co-presenting disability and AOD issues, recognising the

acute challenge of addressing mental health and wellbeing when you don't have stable housing (see page 16)

4. The need to build broader community capacity to support children and young people to receive early treatment and support and disrupt cycles of intergenerational disadvantage and trauma, including:

4.1. Coordination of mental health prevention and early intervention policy approaches with other human services frameworks, including youth homelessness, Child Protection, Child FIRST as well as universal services such as early childhood education and care services and schools (see page 9)

4.2. Additional mental health resources in early childhood education and care services and schools to identify and address the risk factors for developing mental health conditions in babies, children and young people (see page 22)

4.3. Additional mental health funding for flexible learning programs, which have an over-representation of students with complex mental health issues, to embed dedicated mental health workers in education programs (see page 22)

4.4. Further work to build community understanding about the link between childhood trauma and the development of complex mental health conditions later in life, as a way to reduce the stigma associated with complex behaviours, particularly where they intersect with homelessness, disability and AOD issues (see page 25)

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Responses to the Commission's questions

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

Many of the people that MCM support experience complex mental health and wellbeing issues, that are inextricably linked to their experiences of:

- Trauma
- Homelessness at a young age
- Co-presenting conditions such as dual disability (disability and mental health issues) and dual diagnosis (mental health and AOD issues)
- Intergenerational disadvantage
- Discrimination on the basis of gender, sexuality, race
- Social exclusion, including from education, training and employment
- Social isolation, particularly in growth corridors and with newly arrived communities

The complexities that many MCM clients experience demonstrate the intersect between personal vulnerabilities and structural and societal barriers. These factors have been shown to exacerbate underlying mental health conditions, and impact people's ability to navigate multiple service systems to get the mental health care and support they need.

What we see: The instability of homelessness impacts young people's mental health outcomes

- While poor mental health can act as a driver of homelessness, extended periods of homelessness has also been shown to erode people's mental health.[5] Around 6,000 young people aged 12-25 are homeless on any given night in Victoria, and a third of these young people come to Frontyard.[6] In 2018, intake data from Frontyard showed that 48% of young people accessing Frontyard self-reported having a mental health diagnosis.[7] Our clients tell us that:
    - "(Homelessness) has exposed me to drug use/bad behaviour, led to me developing all of the above and being stigmatised"
    - "I personally think that homelessness effects your life dramatically, mental health and physical health"
    - "(Homelessness) makes me unsettled, stressed, worried, it's the start of smoking/drinking"
    - "Felt lonely at first and down, however, I am now stable and comfortable with where I am and with the generous support I am receiving" [currently in refuge]

[5] Johnson, G. and Chamberlain, C. (2011) 'Are the homeless mentally ill?', *Australian Journal of Social Issues,* vol. 46, no. 1: 29–48.

[6] Australian Bureau of Statistics (ABS) (2018) *Census of population and housing: estimating homelessness, 2016,* cat. no. 2049.0, ABS, Canberra

[7] Frontyard intake data

  - "(It's) tremendously terrible, I can't even write about it because it's traumatising. Feeling defeated, isolated and not worthy. Depressed and stuck with own suicidal thoughts. Having people call you dumb and homeless is very difficult.
- Addressing mental health while experiencing the instability of homelessness is an acute challenge for many people. An MCM client observed that:
  - "Mental health becomes a low priority when you don't have housing. Generally you don't have a car or a valid myki but they expect you to travel to them for an appointment."
- Homelessness is often a driver of young people leaving their communities to travel to metro areas where there are more services. This creates further isolation from natural supports and pro-social peer networks.
- When mental health responses are integrated within the homelessness response, success is more likely with both the homelessness and mental health issues.

What we see: There's a strong sense of distrust of the mental health system amongst young people experiencing homelessness

- Many of the clients MCM works with in our homelessness services have had past negative experiences with institutions and services that haven't been able to help them. Clients revealed a deep sense of distrust and apathy with services, a belief that their thoughts and opinions don't matter, and that they had no voice:
  - "Sometimes you need help and are not okay, even if you are not suicidal. But you can't get anything or any help. Mental health people don't want to do early intervention. They only care if you're suicidal, but you can still not be okay even if you're not suicidal."
  - "I'm not the same Grace I was before, I've been hurt, I don't trust, my heart isn't the same. You don't know me anymore."
  - "They (the workers) tell me they need to do handover. I'm sick of workers switching up all the time, abandoning me."
  - "I need to connect but I don't have anyone. I don't know what I would do if I didn't have MCM."
  - [Gail, parent of an MCM disability client currently living in a psychiatric hospital] "I've been trying to teach her to stand up for herself as well. It's so important, when she tells me about her experiences, I say to her why didn't you speak up but she says 'they didn't listen' so she doesn't tell anyone anything. I say 'you've got to, people will listen' but she just says, 'they don't.' I think it would make a massive difference to her if she felt someone was listening to her. She tells me now, 'I don't trust anyone anymore, no one' – and it's just killing me, she hasn't done anything with her life but she has experienced a lot of pain and a lot of suffering and I just want to get her somewhere safe." Gail also notes the constant lack of staff available within the facility to call on for support.
- Staff reported a client who had had negative experiences of mental health treatment, including unwanted side effects from medications and involuntary treatment, and that this perpetuated a fear of further engaging with mental health services, which in turn resulted in further involuntary treatment.

What we see: Many clients don't have the informal supports that are needed to advocate for them and support them to navigate complex systems

- A common trait that many but not all MCM clients share is a lack of supportive family or informal networks around them. It is widely recognised that Australia's mental health system is dependent on an informal caring workforce that if paid, would cost $13.2 billion per annum.[8] A significant proportion of the young people accessing homelessness services come from the Out-of-home care system or are forced to leave home due to family violence or family conflict. In 2018, 64% of young women and 40% of young men accessing Frontyard had experienced family violence.[9] In 2015, around 63% of young people experiencing homelessness nationally had a history of state care.[10]
- These informal supports are critical, and the absence of a carer means that it is often left to services to coordinate the various players and advocate for the needs of people who are acutely unwell. Clients and staff report that people who disengage from mental health and other services are often those who have nobody to advocate for them. Staff in one of MCM's youth refuges provided an example of how this plays out:
    - Al is a 22-year-old client with a history of voluntary and involuntary stays at psychiatric units and has been diagnosed with schizo affective personality disorder, paranoid schizophrenia and episodes of drug induced psychosis and is on a community treatment order. When Al presented at one of MCM's youth refuges, his medications had been changed and he found general day to day living extremely difficult. Al's dose of medication meant that he was unable to hold a conversation or do anything that would assist him to work towards his goals of getting back into education. Al understood that he needed to be medicated. However, the extent that he was medicated meant he was unable to function and had no standard of living.

      The client was engaged with one of MCM's education programs to work towards reconnecting with education and employment. His worker recognised a decline in Al's ability to concentrate for more than fifteen minutes at a time due to his medication.

      Al's mental health support was transferred to the Salt Water Clinic, he requested to have a medication review and due to not being with the service for very long and the clinic, not knowing his presentation, declined his request and advised him that this would not happen for at least three months. Al was devastated with this news and after discussing this with his refuge workers, the MCM team organised a care team meeting with Al's worker from Salt Water Clinic to come and discuss Al's support. Al was present for his care team meeting and was able to demonstrate to the worker from Salt Water Clinic how his medication was impeding his life. With the support of Al's workers advocating for him Al's medication was reviewed and he became more fluid in his daily life.
- The experience of not have informal supports are similarly challenging for clients with dual disability navigating the NDIS. MCM's disability staff provided an example of one client:
    - Sally lives in public housing which she finds unsafe and experiences a range of mental health issues from hoarding, depression, anxiety, and grief and loss. Sally qualifies for NDIS but an error in her plan meant that she was unable to access the services she requested and subsequently her mental health deteriorated. Without any next of kin to

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[8] Diminic S, Hielscher E, Lee Y, Harris M, Schess J, Kealton J, & Whiteford H, (2016) *The economic value of informal mental health caring in Australia: technical report*, pxiii.
[9] Frontyard intake data
[10] Youth Development Australia (2019) 'A national scorecard on youth homelessness.'

help advocate for her needs, and the defined role of disability support coordination (through NDIS) which precludes advocacy, Sally is left on her own to navigate complex administrative systems to get the support she needs.

What needs to be done to address this?

- Young people who present at homelessness services with co-presenting 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. Addressing the drivers of poorer mental health outcomes for these young people requires a broad primary prevention and early intervention lens that addresses the intersecting structural and societal factors at play.

Recommendation 4.1: Coordinate mental health prevention and early intervention policy approaches with other human services frameworks, including youth homelessness, Child Protection, Child FIRST as well as universal services such as early education and care services and schools.

Question 4: What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Staff across MCM services cite multiple cases of being frustrated by the lack of mental health services available to support our clients. While there is widespread recognition that there is a shortfall in availability of mental health services across the state[11], there is additional concern that systemic structures in the sector disproportionately disadvantage many of the clients that MCM supports.

The key issue is that clients who are experiencing homelessness, mental health conditions and other complexities find that their situations are too complex for general services like headspace, and yet for a range of reasons they are not able to engage with more intensive clinical mental health supports. Ultimately, people are left without solutions and appropriate supports – particularly when their issues span across the mental health, health, housing and disability systems.

What we see: young people experiencing homelessness have mental health and other issues that are too complex to be able to access general services designed for people experiencing mild and moderate illness

- General mental health services, such as services that operate on the basis of 10 funded sessions, only go so far in supporting young people experiencing homelessness and complex mental health issues. Limitations on the number of funded sessions means that cost becomes a barrier for many people. Our clients told us:
  - "Psychologists work the 10 free sessions but it's hard when you're not working and you have to pay after the 11th one. As much as you want to still go to more sessions you can't afford it."
  - "headspace – free sessions ran out"
  - "Everyone has the right to seek available treatments, everyone has the right to seek medical specialists, like a GP or psychologist and the current mental health 10 sessions per year is totally inadequate and should be doubled. Ten (10) sessions is beyond a joke it's not good enough as many are forced to stretch out their sessions so they have enough for the year. When people are in a crisis they have more difficulty in seeking help so they struggle, this is never okay."
- General mental health supports also rely on people being well enough to find information, reach out to the mental health sector to make appointments, and to attend sessions autonomously. For young people who are transient and who struggle with reading and writing. have complex trauma histories and low levels of trust in services – service staff find that it is common they would not keep set appointments or would get anxious and not attend. MCM staff report:

[11] Victorian Auditor General's Office (2019) Access to Mental Health Services

- "…there's all of these initiatives for youth mental health, but these young people are invisible because the system has an expectation that they will meet the structure as it is designed, [but] there's nothing structurally coherent or predictable about them."[12]
- "They are not going to community health centres, they are not able to engage with headspace sites, they are not in school and they haven't been in school for a long time so they don't get the school counsellor [or] the psychologist, in so many ways they're not getting access to acute clinical [support] and they're not getting access to long-term therapeutic care…"[13]

- Further, young people who can't engage straight away with goal directed planning are often misinterpreted as 'not engaging,' which is problematic in voluntary services, and leads to them missing out on essential services.

What we see: Young people experiencing homelessness, dual disability and dual diagnosis face structural barriers to accessing intensive clinical mental health supports.

- Clinical mental health services are provided in zoned catchment areas and not all regions offer the same services or operate within the same frameworks. Young people who are experiencing homelessness are regularly required to move across metropolitan Melbourne for temporary accommodation – forcing them to move between the area-based zones of clinical mental health services. The responsibility falls on homelessness services to coordinate area mental health supports for young people across different catchment areas.
- MCM staff report the difficulty in engaging area mental health services in the assessment, ongoing support and crisis management for a person in temporary accommodation. When mental health services are engaged, they generally do not have capacity to remain with the client when the client is forced to move to a different area to access housing:
  - "As the client was often residing outside the catchment area of the Orygen mental health facility she was unable to be case managed on a daily basis and required to engage with the local area CATT [Crisis Assessment and Treatment Team] teams in whichever area she was living, making continuity of care difficult."[14]
  - "Even for someone who technically fits into that category of linking with area mental health service or an external service, I've had a couple of young people who our model says that it should take a day to six weeks, but for one because of the chaotic nature of his living arrangements and to a degree his mental health as well, I was working with him for three or four months before he was linked in with an area mental health service. Because he was jumping between catchments, between states. His phone number was changing almost weekly. He wasn't stopping anywhere so no one could pin him down, and the way that the mental health system is structured is that it's all catchment based. And once he's out [of that catchment area], then it's somebody else's responsibility to follow that on."[15]

[12] Thomas S, Daley K, & Kesic D (2011). *Evaluation of the Melbourne City Mission Check-In Mind Health and Wellness program,* page 35 (unpublished).
[13] Thomas et al (2011), pg. 35
[14] Ibid pg. 36.
[15] Ibid pg. 36.

- Staff reported a case of a 20-year-old client, who presented at Check-In[16] with first episode psychosis. She was referred to Orygen Youth Health for triage assessment and to a refuge in Moorabbin for crisis accommodation (a different catchment area to Orygen's). Orygen was unable to reach her by phone, despite having been advised that she was fearful her phone was bugged so keeps it off, and they closed her due to being out of area. Her Check-In worker attempted to advocate for her to remain with Orygen given the likelihood that she would return to Frontyard for crisis accommodation within the Orygen catchment area. She left her refuge in response to worsening psychotic symptoms, believing the TV was talking to her. Several days later she presented to Check-In and was supported to Eastern Mental Health Service who were able to admit her into an adult ward and transfer her to a Child and adolescent mental health service. Staff note that given that she was regularly in contact with Frontyard and experiencing a first episode of psychosis at the age of 20 years, the most appropriate place to be treated would have been Orygen Youth Health.

- Staff also report that young people experiencing homelessness are excluded from accessing Prevention and Recovery Centres (PARCs) – 'step down' clinical mental health services that offer short-term recovery in a residential setting following a hospital admission – as the model stipulates having a fixed address to return to. The lack of 'step down' options for young people experiencing homelessness means that they can be discharged from hospital after an acute episode without appropriate plans and support to manage their medications and recovery. Staff observe that this leads to persistent cycling between homelessness and emergency services.

- The requirement that people undergo alcohol and drug screenings to be eligible for mental health supports leaves many clients without the supports they need to improve their wellbeing. Staff cite a number of cases where clients have been rejected from accessing supported mental health accommodation due to having a history of AOD issues, or because they haven't been able to engage consistently in the past and their cases get closed:
    - Check-In staff reported a 22-year-old client with a history of childhood abuse and neglect who entered the homelessness system in his mid-teens. He had been diagnosed with intellectual disability, adjustment disorder, attention deficit hyperactivity disorder (ADHD) and schizophrenia, and had developed the maladaptive coping strategy of frequent alcohol and other drug use to self soothe his mental health concerns. While engaged with Check-In, he has had multiple presentations to emergency departments in response to acute mental health distress. After the most recent episode, he was discharged from hospital to homelessness due to behavioural issues, and reported not to have psychiatric concerns. The client is deemed not to be presenting with a psychotic or other mental illness that is appropriate for acute mental health community follow-up, and that his level of risk to self and others is due to his illicit substance use.
    - Staff in refuge spoke of a client, who after cycling through refuge multiple times, was finally ready to access mental health support services. However, her history with the local mental health services in the past - with failure to attend appointments and in the service, having presented 2 years previously but then moved out of the catchment zone meant that now she was unable to qualify for the service. The concern for refuge workers is that the client was expressing readiness to seek support but her past history became a barrier to accessing the service. This frustration led to the client locking

[16] Check-In is an MCM service that provides clinical and therapeutic mental health care to young people accessing homelessness supports at Frontyard.

herself in her room for days and not speaking to anyone. When she finally did speak, her message was '*I was talking but no one's listening*.'

What can be done to improve this:

- Not meeting the right eligibility criteria for specialist mental health services does not demonstrate a lack of need, nor should it mean that individuals are denied essential services for not being able to engage with available programs. It is an indication that the system has not been designed to meet the needs of diverse people. The central question needs to be flipped around to ask what types of services do people experiencing homelessness and persistent and severe mental health conditions need?
- There is a clear need for the development of clinical mental health services, including 'step down' models, for young people experiencing homelessness who are currently unable to access area mental health services due to their transience.
- There is also a shortage of non-clinical mental health services that could help address non-medicalised needs. Families and community services lack the specialist mental health skills and expertise to manage on their own, and become reliant on emergency services when extra support is needed. This in turn impacts on the emergency sector who are forced to pick up the shortfall, even if this is not the most suitable option.
- Throughout the consultation for this submission, clients have provided insights about where they see the gaps in services and the approaches that would better meet their needs. Suggestions included more options, greater flexibility and drop-in models, and the importance of non-judgmental approaches:
  - "Every major shopping centre in problem areas ie Box Hill, Sunshine, Ascot Vale etc should have drop in services with a full range of services, GP, nurses, counsellors"
  - "[Need for crisis hubs] where anyone can go, where they can feel safe and secure and not judged. A little goes a long way, enough staff who are medically trained to be there because sometimes all someone needs is a person who can ask them are you okay. Nobody wants to be judged when they are at their most vulnerable state."
  - "I think the thing that would help the most is having services that all talk and link up with each other, that means mental health, youth workers, youth shelters if you're homeless, which I think kind of happens but a one stop shop would be easier. Same if it was all available on one website."
- MCM has developed a number of services that are designed to work flexibly to engage young people in mental health supports who have fallen through the gaps of mainstream services. Two examples, **Check-In** and **Cradle to Kinder**, are provided in the section 'learning from promising practice' below.

Recommendation 1.1: Fund additional youth-focussed clinical mental health services that are designed to meet the needs of young people experiencing homelessness who are currently unable to access area mental health services. New services should be co-designed with young people, to ensure young people with the most complex needs are able to engage with clinical mental health supports.

Recommendation 1.2: Fund additional general mental health and wellbeing services for young people experiencing homelessness and other complexities including trauma, AOD issues, disability that address whole-of-person wellbeing needs, as an alternative to current mainstream services which our clients struggle to engage with.

What we see: People with complex mental health issues who need support from the mental health, disability and housing systems are left without solutions and appropriate supports

- The lack of integration between the mental health, disability and the community sectors is a major barrier to people with complex mental health issues being able to access and experience mental health treatment and support.
- The experiences of people with co-occurring disability and mental illness vary widely – some are supported by the NDIS, while many are not eligible for NDIS and are not adequately picked up by the mental health sector.[17]
- The lack of suitable and coordinated mental health, housing and disability services responses means clients with complex needs are making do in crisis accommodation services and can't get access to the mental health services they need. Similarly, some clients are forced to stay in mental health facilities because there aren't appropriate housing options to exit into. Families and community services are left to manage on their own when someone has been discharged because appropriate mental health services don't exist or are at capacity:
    - Staff provided an example of a 22-year-old client staying in a 6-night bed at an MCM youth refuge. The client is a heavy user of illicit drugs and had complex mental health issues, was under the direction of a Community Treatment Order, and was being supported through Orygen mental health. She had weekly depot injections and a variety of other anti-psychotic and anti-anxiety medications supervised daily by the local CATT team. The client had been living in crisis accommodation since she was 18 years old and had no family supports or friendships. The client needed supported accommodation and was on a wait list for longer term refuge accommodation, and in the meantime was being referred to short term or overnight beds, or hotel accommodation in many different areas, making it difficult for her to access medication and the daily support she needed for her mental health issues.
    - Staff reported a similar case of a 22-year-old client who was referred to an MCM youth refuge after being exited from a Supported Residential Service (SRS). The SRS advised she was exited due to calling 000 whilst living at the facility too many times, as she was having audio hallucinations and became abusive. The client has an extensive list of disabilities and mental health diagnoses, ranging from minor Spina bifida, Type 2 Diabetes, Intellectual disability as well as Borderline Personality Disorder, Schizophrenia, Bipolar and Autism, and complex trauma presentations. She is supported by Neami services and whilst finding herself homeless, the client stated she felt comfortable and supported whilst at the youth refuge. The likely exit plan will be another SRS facility.
    - Gail, the parent of an MCM client who has cerebral palsy and complex mental health issues spoke about her daughter, Katie, remaining sedated and in a psychiatric hospital

[17] Mental Health Victoria (2018) *Saving lives. Saving money. The case for better investment in Victorian Mental Health.* Available from: https://www.mhvic.org.au/images/PDF/Policy/FINAL__Saving_Lives_Money_Brochure_HR.pdf

for years because of the lack, amongst other factors, of adequate housing which could also support Katie's physical disability needs:

"She lives at the hospital, we can't find a place for her to live. And it's been years!... She's been lying on her bed all day, every day, staring at the ceiling. She needs to be in the right environment, being encouraged…. Look the staff over there are fantastic but she needs to get out of there. She needs a place away from there and because she has needs with her disability this is an issue. There's nowhere to go.

"Trying to find suitable housing for Katie has become impossible. I've given up. What housing is around is miles away and I don't want her far, but even then I don't think it's appropriate or available… And when accommodation does come up its not appropriate for her, they won't have the accessibility needed for her disability."

- Lack of coordination between different sectors also can lead to people being treated for only one element of their broader wellbeing needs. Gail spoke of the challenges over the years for her daughter whose mental illness has been medicated, but her disability and ability to function is diminished:
  - "So these medications are sedating her, which are making it really hard for her to walk. Now whilst her cerebral palsy has not required any medication, Katie has done extensive physio all her life, and had multiple operations – she wasn't meant to be able to walk but she can! She's worked really hard and this had a huge mental impact as well. Other than the stress, there's also the energy from all the work she's done in being able to walk. And then you give these big, heavy sedating drugs – and they're very difficult. And they weren't listening to me or her. … And the impact of the drugs, they've messed with her weight and her mobility."

    "[After persistently advocating for Katie to get access to mobility supports within the psychiatric hospital] Finally about a month ago they got a walking frame for her, and she's not allowed to use it because they think she could use the frame as a weapon. There's a bar on the frame that can be removed which they think is unsafe, so I said 'do something about it, so she can use the frame'... I still haven't heard back if it has gone to be repaired. At the moment, Katie can only have the frame when she is going out, but as she has no carers at the moment she is not even going out. She's been lying on her bed all day, every day, staring at the ceiling."

    "But the other thing I want for her is some counselling for her sexual abuse, you can't recover without it. Medication won't fix this but at the moment the hospital won't allow any type of counselling. Similarly, no counselling or therapy to help with her Borderline Personality Disorder. I've been asking for it for years, and before she became really bad recently, we had started to go to [counselling services] with her. But at her second appointment, everything collapsed – mind you they had changed her medications the day before but that was the last interaction we had with [counselling service] as she was hospitalised shortly after. The hospital feels that external counselling interferes with what they are doing with Katie. So right now, it seems everyone is treating symptoms but no one is looking at the cause. No one is helping build her abilities or her life skills and she had been pretty good but she's deteriorated to such a point that she can barely move, her brain isn't being stimulated, being in that environment you can see the impact it is having on her."

- These challenges also play out in terms of funding – where clients have access to NDIS supports and mental health supports, but funding is provided by different funding bodies and don't link up to provide whole-of-person care:
    - "Worse, we have a package from the NDIS for Katie but because she's in the hospital we can't use it. It's part of the NDIS framework. It's a massive, massive problem… I just wish that the NDIS and DHHS funding would talk to each other. We have a good package from NDIS but we can't really touch it."
- Gail's daughter's experience of overlapping mental health, disability and housing issues highlights the difficulties in getting sectors to coordinate to develop solutions that address all aspects of a person's wellbeing.

What can be done to improve this:

- Alternative models of supported mental health accommodation need to be developed. There needs to be more options of supported mental health accommodation for people who don't have housing and who have co-presenting disability and dual diagnosis.
- Better coordination and planning is needed between the mental health, housing and disability systems to develop solutions for people with complex needs, including by:
    - Ensuring that all human services-related qualifications have mandatory units on mental health;
    - Building the capacity and skills of the workforce outside of the mental health sector to support people with mental illness;
    - Supporting the expansion of multidisciplinary teams and mental health clinicians working in the broader community sector; and
    - Enabling the sharing of information on client mental health history and diagnosis with community services.

Recommendation 2.1: Improve coordination and planning between the mental health, housing and disability systems to develop solutions for people with complex and overlapping needs, through building the mental health knowledge and skills of community sector professionals, embedding mental health clinicians in community services, and enabling the sharing of information on client mental health history when relevant.

Recommendation 2.2: Fund specialist mental health support functions within the NDIS to support people with co-presenting disability and mental health issues and disability workers, to navigate the interface between the mental health and disability systems.

Recommendation 3.1: Increase investment in housing options for people with complex mental health issues who don't have housing and who have co-presenting disability and dual diagnosis, recognising the acute challenge of addressing mental health and wellbeing when you don't have stable housing.

Learning from promising practice: Check-In & Cradle to Kinder

MCM's 'Check-In' service provides clinical and therapeutic mental health care targeted to the 'hard to reach' population of young people experiencing homelessness

The Check-In mind health service is provided by a multidisciplinary group of Youth Mental Health Clinicians for people who are at risk of, or currently experiencing homelessness. Check-In is for people aged 12 to 24 and addresses psychological distress and challenging, at risk or suicidal behaviours.

The model uses a 'stepped model of care' which is a flexible approach that enables young people to move between different types of supports depending on their mental health needs. Check In's five support levels include:

1. **Rapid response:** assessment and triage to respond to young people in acute crisis, linking them in to emergency assessments by specialist mental health services in the first 48 hours of a crisis.
2. **Service navigation:** a period of brief engagement and intervention, from 48 hours up to 6 weeks that caters to young people who may be experiencing deteriorating mental health who would benefit from non-crisis referrals to clinical mental health services.
3. **Counselling:** short-term recovery-oriented care and supports for young people at risk of deteriorating mental health, ranging from between 1 week and 6 months.
4. **Therapeutic engagement:** longer-term supports for young people who are at risk of deteriorating mental health in the context of experiencing ongoing and intersecting adverse life events, including homelessness.
5. **Secondary consultation:** Check-In clinicians provide secondary consultation support to co-located staff at the various services based at Frontyard. This enables staff and young people to receive an immediate response in crisis situations and improves the mental health literacy of co-located service staff.

Young people can enter the program at any stage, and transfer between the different types of support. An evaluation of the Check In 12-month pilot program conducted in 2018 highlighted a number of success factors for the Check-In model, including:

- **Trauma-informed approach:** A key part of the model is the focus on complex trauma and providing a trauma-informed framework of practice with therapeutic interventions that steer away from a focus on symptoms. Check-In clinicians undergo ongoing trauma training so that young people accessing the service can receive a tailored response that considers their complex needs;
- **Flexibility of the model:** enables young people to remain engaged with the service despite fluctuating and often chaotic attendance, and unstable housing – factors that would likely see them excluded from other services. The 'drop in' feature of the program decreases access barriers so young people can get help when they need; and
- **One-stop-shop:** integration of a range of homelessness, health, wellbeing, financial and legal services on one site enables a holistic approach to young people's wellbeing.

Example of how the Check-In mind health service supports young people to engage with mental health services:

- Steph has a history of homelessness and transiency, dating back to when she was just 13 (she is now 25). She obtained an Office of Housing property due to her vulnerability and high need for housing, but was given no support after obtaining housing, and as a result, would spend her days in the city begging and using heroin, despite having housing and being on the disability support pension. Steph reported that she 'didn't know how' to sleep in a bed, or live within four

walls and articulated that the streets were a part of who she was and were a comforting and safe place to return to.

- Steph was engaged with Frontyard Youth Services and her worker introduced her to the Check-In service. Steph developed a rapport with her Check-In worker, Dave, despite her history of acute distrust of case managers, mental health services, hospitals, psychiatrist and community services due to poor experiences she had had in the past. Ultimately she felt that Dave was someone who was there to support her and not admit her to a hospital.
- Within 8 months, Steph had made strong progress including:
  - No longer begging in the city
  - Being on the methadone program
  - After 8 months, she gave her address to her workers and allowed them to do home visits
  - Agreed to being linked into a structured mental health service
  - Accessing an NDIS package and will get support with activities of daily living
  - Arranges her own transport to go to her appointments with her GP and mental health supports (a significant achievement compared with missing them or not making them a priority)
- She reports that her general wellbeing and quality of life has improved and has a willingness to 'clean up her act' (as she puts it). Of her Check-In worker, Steph said:
  - "Dave restored my faith in the mental health system, he undid years of trauma and hurt in the time I worked with him. He regained my trust in workers."
- When asked what Dave did differently to create such a huge impact, Steph said:
  - "For the first time in my life, Dave actually listened to me and my needs, rather than telling me what I need, he asked me what I needed and worked within that"

The Cradle to Kinder program is an intensive, long term early childhood parenting support program for vulnerable young mothers

The DHHS funded program works intensively with the most vulnerable families, including parents who have had involvement with Child Protection, issues with drug use, homelessness and intellectual disability. The program is focussed on the child's development by improving parenting skills in the early years as a way to break the cycle of intergenerational trauma and ensure that children can remain with their families.

The program works from before birth and continues up to the time the child reaches 5 years of age with the same 'key worker' over the course of the program.

Cradle to Kinder and Aboriginal Cradle to Kinder are Victorian government initiatives delivered across 27 sites in Victoria by community service organisations. MCM leads the delivery of Cradle to Kinder in North Eastern Melbourne, Brimbank Melton and Western Melbourne.[18]

Mental health challenges for young pregnant women and young mothers:

Most of the young mothers referred to the program have an extensive history of trauma, and two thirds of the mothers have a prior or current mental health concern identified by their key workers.

[18] Some elements discussed in this section are unique to MCM's delivery of Cradle to kinder model and may not be replicated in other contracts.

Key workers support their clients to access a range of mental health supports including through GPs, headspace, Orygen, Mother-baby psychiatric units, specialist psychological supports for mothers (Mums Matter), and services for borderline personality disorders (Spectrum).

Cradle to Kinder program staff observe a range of challenges that their clients face in accessing mental health services, including:

- Low levels of trust in services amongst clients with chronic mental health issues who withdraw from services even when they are difficult to access because of low trust.
- Clients with chronic depression whose cases get closed if they don't answer a phone call;
- Clients with borderline personality disorders who are denied treatment citing clients' life circumstance as the cause;
- Lack of access to play-based therapies for children – most available services are not bulk-billed;
- Difficult to get access to child and adolescent mental health services (CAMHS) and Take Two due to narrow eligibility criteria and long waitlists.

Model of support

The Cradle to Kinder model provides some positive learnings for how mental health services can be better designed to meet the needs of people with persistent and severe mental health conditions living in vulnerable circumstances. There are a number of key elements to the model:

- **Assertive outreach** approaches are used to establish relationships of trust and enduring partnerships with families. Key workers engage with clients in the home, transport clients to appointments, and take opportunities for informal contact, for instance meeting parents at school, kindergarten and childcare drop off and pick up times.
- Key workers support families to **navigate mainstream health and social services** and support families to develop confidence in accessing these services in the future;
- Key workers **engage families** through focusing on the development of trusting relationships over time – relationships are seen as the key to building the competence and confidence of children and young parents; and
- Supports are provided with a **whole of family** lens – which considers the family's circumstances, and the existence and experience of the child. One of the barriers for young mothers in the mental health sector is the focus on the patient rather than consideration of their broader circumstances.

Therapeutic component of MCM's Cradle to Kinder program:

MCM's Cradle to Kinder program offers a therapeutic component through child-led family therapy sessions. The program engages a specialist clinician, Dr Wendy Bunston, to work with families and their MCM key worker. The family therapy sessions address the effects of extreme trauma experienced by children and support parents to understand events from the perspective of the child. The sessions enable parents to reflect on their own circumstances, their childhoods, their children's future and the need to access supports.

Key workers participate in the sessions which enables them to build their understanding and relationship with the family, with the added benefit of professional development. Program staff report that most families prefer to attend Dr Bunston's sessions with the key worker present than accessing community psychological services with which they have lower levels of trust.

By building parents' understanding of their own experiences of trauma, supporting parents to build their parenting skills and offering psychoeducation to parents, staff observe that Cradle to Kinder serves as "early intervention in mental health for the next generation."

Question 2: What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

MCM recognises that childhood experiences of trauma are a contributing factor to the development of chronic mental health conditions later in life. Experiences of complex trauma are shared by many of the young people accessing MCM's homelessness services.

Supporting children and young people who have had early childhood adverse experiences (ACES) to get early treatment and support is critical to preventing the onset of more complex mental health issues later in life, and to disrupting the cycle of intergenerational trauma and disadvantage.[19]

MCM can provide comment on two elements of early intervention – early in life and early in episode.

What we see: Schools play an important role in identifying and supporting young people to address their mental health early in life

- MCM's independent school the Hester Hornbrook Academy provides flexible learning and education to students who have multiple and complex disadvantage and concurrent high support needs. Many of the students who come to the Academy have been excluded from the mainstream school system.[20] In 2018, 65% of students enrolled at the Hester Hornbrook Academy were determined to require substantial and extensive adjustments to address 'social/emotional disability' and enable their access and participation in education.[21]
- Student wellbeing is a key focus for the Academy, where teams of youth workers and educators work together to monitor and respond to every student's wellbeing needs on a weekly basis. The Academy staff have developed a wellbeing tool kit which assesses students' support needs across housing, AOD issues, mental health issues, relationships, family issues, physical health, legal issues and financial hardship issues. Each domain is rated on a scale of no support required (1) to high level support required (5), where a rating of 3 to 5 prompts a response from staff.
- For the mental health domain, staff monitor students' attendance and engagement in the classroom, look for signs of withdrawal, and explore referrals to external agencies when required. Where staff are aware of students having complex mental health issues, their youth worker will request support from mental health agencies and join the students' care team where available. Educators are made aware and adjust education delivery to meet student's social and emotional needs. However, access to specific mental health supports for students is reliant on mainstream services, with all the barriers to access discussed in question 4.

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[19] Wall L, Higgins D & Hunter C (2016) 'Trauma-informed care in child/family welfare services.' *Australian Institute of Family Studies,* CFCA Paper No. 37. Available from: https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca37-trauma-informed-practice.pdf

[20] Melbourne City Mission (2016). Submission to the Ombudsman Investigation into Expulsions at Victorian Government Schools. Available at: https://www.mcm.org.au/about/our-publications

[21] Data sourced for the Department of Education and Training's Nationally Consistent Collection of Data (NCCD) on School Students with Disability (NCCD). The category of social/emotional disability applied in the NCCD is defined as 'a disorder, illness or disease that affects the person's thought processes, perception of reality, emotions or judgement, or that results in disturbed behaviour.'

What can be done better:

- Preventing the onset of mental health issues early in life requires a community-wide response. Future reforms should consider building better links between the mental health sector and the education sector to use the universal platform that preschools and schools have, to better identify and support mental illnesses developing in children and young people. One approach that could be explored is to direct early intervention to children who rate on the Adverse Childhood Experience scale.[22]
- Flexible learning programs have an over-representation of students with complex mental health issues. Reforms should consider providing additional mental health funding from state government, in addition to their education focused funding, to enable them to embed dedicated mental health workers in flexible learning programs.

Recommendation 4.2: Embed additional mental health resources in early childhood education and care services and schools to identify and address the risk factors for developing mental health conditions in babies, children and young people – to interrupt cycles of intergenerational disadvantage and trauma.

Recommendation 4.3: Provide additional mental health funding for flexible learning programs that have an over-representation of students with complex mental health issues, to embed dedicated mental health workers in their education programs.

What we see: Creative approaches are needed to prevent the escalation of mental health crises early in episode for young people experiencing homelessness

- When young people aren't getting access to the ongoing mental health supports that they need, mental health episodes have a much greater tendency to escalate to crisis point. This is a far too regular occurrence in youth homelessness services, and incidences commonly occur in youth refuges after hours when there are few options but to call emergency services. This doesn't always lead to the best care outcomes for young people, and puts additional pressure on emergency services.
- MCM is exploring ways to prevent young people's mental health episodes from escalating to crisis point by offering a range of therapeutic programs on site with homelessness services. A clear area of need is an alternative to 'talk-based therapy', which many clients won't engage with. A client observed that:
  - "feeling pressured to actively seek help certainly doesn't help my mental wellbeing, in my experiences. When you get pressured or feel like you have to attend appointments or go to meetings, I feel like as an individual you tend to not get as much out of it as you would if you sought out the 'help' yourself."

[22] Wall et al (2016)

- As a response, Frontyard offers music therapy, art therapy, animal-assisted therapy, trauma-sensitive yoga and sensory rooms as a way to reduce stress and anxiety, build young people's capacity to manage negative emotions and repair the impact of past trauma. Animal-assisted therapy is an alternative to traditional therapy that has been shown to support young people with histories of trauma to develop life skills and support them to interact positively with their peers.[23] MCM has offered an animal assisted intervention program at Frontyard since 2016, delivered by a specialist psychologist in collaboration with Frontyard's homelessness staff. The program involves weekly three-hour sessions held at Frontyard where young people can take part in semi-structured activities with the therapy dogs. A recent evaluation of the program found that the program reduced negative emotions, had a calming effect and that participation in the program improved young people's social relationships.[24] Some observations from young people include[25]:
    - "I feel less anxious"
    - "My mental health has improved I am a lot calmer and happier"
    - "Feel safe. One of the reasons I keep coming back. The dogs make me feel very safe."
    - "I have a better ability to engage with my workers after seeing the dogs"
    - "The dogs have made it easier for me to talk to other people at Frontyard".
- MCM is also providing new ways to support young people with complex needs in crisis accommodation, where it is common for mental health episodes to escalate after hours. MCM's newly developed CBD accommodation for young people experiencing homelessness provides 24 hour support to ensure that young people can get the assistance they need, even if it's outside of business hours. While the accommodation is only recently opened, a young person interviewed for this submission highlighted the value of the 24 hour support in helping her with anxiety:
    - "They do 24 hours supervising and it helps a lot, especially for me. I have a lot of panic attacks especially at night and it helps to come out (into the lounge space) and I can sit with a worker to talk or watch a movie. But when I've had a panic attack at the other refuges I couldn't talk to anyone because at the other refuges they sleep at night, which is why we have curfews. So the workers could sleep, which I can understand but often it's at night when you want to reach out to someone. The other difference between here and other refuges – normally you have to go to the workers, you have to find them, but here they are moving around, they come and talk to you.

What can be done better:

- Embed additional mental health clinicians in community sector organisations to intervene early before young people's mental health crises escalate. Examples of approaches that can be scaled include MCM's Check-In model and the Homeless Youth Dual Diagnosis Initiative (HYDDI)

[23] Kelly M, & Cozzolino C (2015) Helping at-risk youth overcome trauma and substance abuse through animal-assisted therapy. *Contemporary Justice Review, 18*(4), 421-434.
[24] Heerde J (2019) *"I can be me again": Animal Assisted Interventions with young people experiencing homelessness. Report of program implementation and outcomes* (forthcoming). Department of Paediatrics, Melbourne Medical School, The University of Melbourne. Parkville, Australia.
[25] Ibid.

program.[26] HYDDI has mental health workers going into youth refuges on a weekly basis to talk to clients, build rapport, and provide secondary consultation to assist in building the capacity of homelessness refuge workers to deal with mental health and AOD issues. Resourcing the community sector to be able to employ mental health clinicians with salaries that are competitive with the health sector is another important consideration.

- Provide additional resources for a dedicated crisis response service that works directly with community service professionals supporting young people with complex mental health issues. The crisis assessment and treatment team (CATT) and Police, Ambulance and Clinical Early Response (PACER) provide crisis response to the general population, however, a service that works directly to support homelessness service workers would provide a more targeted and effective alternative.

- Another area for improvement is support for community services that work with young people with complex mental health needs to expand operating hours beyond the traditional hours, where appropriate.

Recommendation 1.3: Fund additional resources for a dedicated mental health crisis response service that works directly with homelessness services and other community service professionals who have assessed an acute and immediate response is needed for a young people person they are supporting.

Recommendation 1.4: Support mental health and human services that work with young people with complex mental health issues to have expanded operating hours, recognising that mental health episodes have a much greater tendency to escalate to crisis point after traditional business hours.

[26] Homeless Youth Dual Diagnosis Initiative. Available from: http://www.nwhn.net.au/admin/file/content2/c7/HYDDI%20Pamphlet.pdf

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

What we see: Inroads have been made into reducing the stigma and discrimination associated with anxiety and depression, however, more complex conditions are still misunderstood

- Organisations such as Beyond Blue have helped to normalise the experience of mental illness, and have given rise to schools and workplaces putting in place better mechanisms to support and talk about some mental health conditions.
- There is still a significant gap in broader community understanding about the more complex mental health conditions, particularly as they intersect with experiences of homelessness, disability or AOD, which are not universally experienced. As a community, there is still a fear of violence from people with mental illnesses who present as unpredictable or aggressive.
- Underpinning this, there is a need to build community understanding and awareness of how complex childhood trauma contributes to the development of mental health conditions, complex behaviours and AOD issues later in life.
- Conditions such as Borderline Personality Disorder (BPD) are frequently misunderstood, even within the mental health sector. The condition is often misdiagnosed as bi-polar or other major depressive disorders, with common stereotypes persisting that people with BPD "are dramatic, manipulative and attention-seeking."[27] Lucy, a client of MCM's disability services provided some insights into her experience:
    - "Being diagnosed with a mental health condition has made me aware of how much is still not being done to support people living with BPD or other mental health conditions. In fact most people struggle with standing up for themselves or fighting for their basic human rights." Lucy has provided a full written statement available in **Appendix A.**

Suggestions for improvement:

- There is a need to build community understanding about the more complex mental health conditions, particularly the link between childhood trauma and the development of complex mental health conditions later in life.

Recommendation 4.4: Build community understanding about the link between childhood trauma and the development of complex mental health conditions later in life, as a way to reduce the stigma associated with complex behaviours, particularly where they intersect with homelessness, disability and AOD issues.

[27] Salters-Pedneault K (2019) *Understanding Stigma When You Have BPD,* Eastern Connecticut State University. Available from: https://www.verywellmind.com/stigma-a-definition-of-stigma-425329

Question 9: Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Drawing from the stories and observations of MCM's diverse client groups and staff, the key priority areas for reform are:

1. The need for additional mental health services designed to support clients experiencing homelessness, dual disability, dual diagnosis and disadvantage more broadly

This would include the design and implementation of a range of supports, such as:

- Clinical mental health supports, including 'step down' models, for young people experiencing homelessness who are currently unable to access area mental health services due to their transience;
- Access to youth-specific clinical supports in every region – Orygen Youth Mental Health is the only one currently, and operates only in the North West region;
- Additional mental health services that address the non-clinical mental health needs of young people experiencing homelessness, dual disability and dual diagnosis who haven't been able to engage with mainstream supports.

Service design for these cohorts should consider:

- **Flexibility:** to work with young people over longer time periods given the instability associated with moving between different catchment areas to find housing and difficulties attending regular centre-based appointments;
- **Assertive outreach:** to build relationships with young people who traditionally have low levels of trust in services;
- **Non-judgmental approaches**: to address ongoing stigma associated with more severe mental health conditions and homelessness;
- **Addressing the needs of the whole person**: young people with complex mental illnesses may not be ready to address their issues through direct counselling, however, one-stop-shop models with co-located services enable a variety of needs to be met;
- **Support to connect with mainstream services:** particularly important for people who don't have informal family supports to help them navigate complex systems.

There are further implications for how mental health supports are funded. The Royal Commission should consider how mental health funding can be better targeted to need, particularly for people with complex mental health issues and co-occurring homelessness, AOD issues and disability. Fragmentation between state and federal level funding must be addressed for these cohorts.

2. The need for better coordination and planning between the mental health, housing and disability systems to develop solutions for people with complex needs

"And I've been trying to say to the medical professionals, it's the big picture – her physical, mental health and everything is impacted by her experiences and we need to work on the whole picture but I haven't been listened to. Or maybe it doesn't fit into their systems of working, I don't know."

"Years go by and I've met so many people and restarted again. There needs to be a criteria that says if you take a job like this you need to be in it for a certain amount of time because we are not moving forward. I'm thinking this needs to be a recommendation for the future because it is so much time wasted. All these people are running around and doing lots of paperwork, and going to meetings, they're all getting paid and this patient is just sitting there and nothing is happening for their benefit."

(Gail, parent of MCM client Katie)

Fragmentation in how mental health, disability and community supports are delivered leaves too many people without the appropriate supports that address their broader wellbeing needs.

The Royal Commission should consider strategies that support the mental health sector and broader human services to coordinate service responses for people presenting with complex mental health issues. This could include:

- Introducing a mandate that all human services-related qualifications have compulsory units on mental health;
- Building the mental health understanding, knowledge and skills of the workforce outside of the mental health sector, such as homelessness and disability service workers, to better identify and respond to emerging mental health issues in clients with complex and overlapping needs;
- Supporting programs that have multidisciplinary teams, as well as incentivising more mental health clinicians to work in the broader human services sector. The Homeless Youth Dual Diagnosis Initiative (HYDDI) program[28] has mental health workers going into youth refuges on a weekly basis to talk to clients, build rapport, and provide secondary consultation to assist in building the capacity of homelessness refuge workers to deal with mental health and AOD issues. Isolated examples such as these need to be reviewed, to extract what works well and scale up the components that work;
- Enabling the sharing of information on client mental health history and diagnosis with broader human services when clients' mental health issues are relevant to their homelessness and disability service responses. This would enable community services to form more appropriate support plans and manage risk.

3. The need for increased investment in housing options for young people with severe and persistent mental health issues

MCM supports a Housing First approach that acknowledges that secure housing is a fundamental human right, and an absolute necessity to be able to address mental health issues. Stable housing is a vital first step that enables people with co-presenting homelessness, mental health and disability to address their mental health and wellbeing.

[28] Homeless Youth Dual Diagnosis Initiative
http://www.nwhn.net.au/admin/file/content2/c7/HYDDI%20Pamphlet.pdf

Mental Health Victoria recommends the need for an investment of $110 million on Housing First initiatives for 3,000 young people in Victoria, that provides access to physical housing as well as community care, outreach, and intensive support to maintain housing and support stability.[29] MCM supports this approach, and recommends that future housing initiatives are designed for people with co-presenting and complex needs – including disability, AOD issues and trauma, as well as the need for a specialised approach to Housing First for young people that sits outside of the adult framework.

4. The need to build broader community capacity to support children and young people to receive early treatment and support

Noting that childhood experiences of trauma are a contributing factor to the development of chronic mental health conditions, supporting children and young people to get early treatment and support is critical to preventing the onset of more complex mental health issues later in life. Effective prevention and early intervention requires strategic planning at the system-level and community wide efforts, including:

- Coordinating mental health prevention and early intervention policy approaches with other human services frameworks, including youth homelessness, Child Protection, Child FIRST as well as universal services such as early childhood services and schools;
- Embedding additional mental health resources in early childhood education and care services and schools to identify and address the risk factors for developing mental health conditions in babies, children and young people – to interrupt cycles of intergenerational disadvantage and trauma;
- Providing additional mental health funding for flexible learning programs, which have an over-representation of students with complex mental health issues, to embed dedicated mental health workers in education programs; and
- Building community understanding about the link between childhood trauma and the development of complex mental health conditions later in life.

[29] Saving lives, saving money, Mental Health Victoria

Conclusion

This submission draws from the stories and observations of MCM's diverse client groups and staff. The submission has sought to highlight the inequitable barriers that many MCM clients face in accessing mental health supports. Future reforms to Victoria's mental health system must consider the needs of people with the most complex mental health issues, particularly as they intersect with experiences of homelessness, disability, Alcohol and other Drug (AOD) issues, and structural and societal barriers including poverty, social exclusion and discrimination.

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Appendix A: Statement provided by Lucy Veldze, an MCM client

My mental health disability has impacted my everyday life in many different ways. In particular it has made my social life and interacting with others in the community very challenging as I navigate my way in life.

I am also battling an autoimmune illness called ANCA Vasculitis. It's not only rare as I was 25 when diagnosed, but it's nearly claimed my life on several occasions. Without the help and support of the Disability Support Payment I wouldn't be able to afford all the medication I am currently on for this autoimmune illness and this is why I am unable to take any of the medication currently on trial for Borderline Personality Disorder (BPD). This has made my day to day life extremely difficult for me as I have to ride the stress of BPD through without the assistance of any of these drugs on trial which leaves me exhausted and mentally unable to function at times.

What helps support me with my mental wellbeing is being connected to my Psychologist, Elise who specialises in BPD. Elise has absolutely helped with strategies and helped me navigate the best therapy available for BPD. Without the ongoing support from my GP, Dr Lorna and Elise, I would be left to my own devices and continue to struggle with my everyday life.

My family are also the strength in my wellness and have helped me in different ways and when I need advice, I am one of the very fortunate ones who have their mum Jude advocating for me and fighting the system for my basic needs and rights. Five years ago, I was struggling with my health which caused enormous stress on my mum. Without Mum's help, I would be still struggling. For me, family and medical specialists are the key to helping navigate my options.

So more needs to be done as there is a growing number of people who suffer from mental illness who do not have family or medical support because of the limiting nature of a mental health illness to seek help in the first place, then the therapy options are very expensive or they have very limited capacity to meet the demand. This then forces patients to be put onto very long waiting lists or be turned away from treatments because they have no money or they are living on the streets, which is a complete abuse of their basic human rights and in that situation, they do not have the capacity to seek help, they can only try to manage their day to day survival.

Since my diagnoses of BPD, nothing in my view ever says mental health doesn't matter, because it does. Mental health conditions are on the rise and if something isn't done to help the funding and recognition of this crisis, it will become an epidemic and be one of the world's biggest killers. Mental health conditions do not discriminate and can affect anyone at any time.

Being diagnosed with a mental health condition has made me aware of how much is still NOT being done to support people living with BPD or other mental health condition. In fact, most people struggle with standing up for themselves or fighting for their basic human rights.

Treatments need to be more available for those no matter where they live, particularly those in the regional areas and people living in poverty and low income. Very few people can afford private treatments, so help needs to be open to all, regardless of circumstances.

Spectrum is the only organisation that I know who specialise in BPD in the State of Victoria, so what happens to those living in Central Victoria, Darwin, Queensland? How do those people access help? Not all GP's are aware of an organisation such as Spectrum, luckily mine does. This is a crisis of its own; it's one condition in the mental health spectrum and is on the rise. BPD can be treated successfully, but it takes on average 2 solid years of therapy and specialist treatments to recover

from this condition. DVT or dialectal behavioural therapy is only treatment available and there are limited places available. Naturally you need a referral from your GP or Psychologist and some people do not have access to either of these services so it makes it impossible to even get started.

There is medication on a trial basis for those suffering from BPD the Spectrum specialists don't even know if this trial medication will work for everyone suffering from BPD. In my case I also have a kidney condition and because of medications prescribed for my ANCA Vasculitis I am unable to trial these medications making it especially hard for me, which is taking a toll on my health. I only have the support of my Psychologist available to me.

Opening more BPD crisis centres or crisis HUBS, where anyone can go, where they can feel safe and secure and not judged. A little goes a long way, enough staff who are medically trained to be there because sometimes all someone needs is a person who can ask them are you okay. Nobody wants to be judged when they are at their most vulnerable state.

Research is an important part of how we can all better understand how mental health happens and why some people are more prone to mental health illness than others, it's absolutely critical that more money is put into the scientific studies, without this research many people will go without the vital help or access to medical treatments or programs. More needs to be done to scientifically test these trial medications so more facts can be found out whether more people with BPD can use these medications or whether it helps only a small population with the BPD condition.

So, in closing I can't stress how important mental health is to everyone regardless of how much or how little money they have.

Everyone has the right to seek available treatments, everyone has the right to seek medical specialists, like a GP or psychologist and the current mental health 10 sessions per year is totally inadequate and should be doubled. Ten sessions is beyond a joke it's not good enough as many are forced to stretch out their sessions so they have enough for the year. When people are in a crisis they have more difficulty in seeking help so they struggle, this is never okay.

We really need more people to understand we are at dangerous levels of mental health need in this country and if it continues like it is, there will be more suicides and more people facing mental health on the streets and longer waiting lists. We desperately need the help and treatment now.

The level of service available is unacceptable; more minds need to be open to massive changes across the mental health spectrum and not just in BPD.