



To Whom it May Concern

drummond street services/queerspace welcomes the opportunity to submit to the Victorian Government's Mental Health Royal Commission. This submission follows our earlier correspondence in November 2018 and commentary on the Royal Commission's initial draft Terms of Reference.

drummond street services reiterates, if undertaken comprehensively, this Inquiry and subsequent follow-through by the Victorian government should:

- bind and guide future investment in mental health prevention, early intervention, crisis and recovery services over the immediate and longer terms
- ensure non-partisan approaches to mental health public policy, funding and service delivery
- provide the framework and mechanisms to reorient funding intentions, including programming and initiatives across a spectrum of interventions which apply community-based family and children models alongside clinical interventions
- ensure allocation of new monies to validated, innovative and outcomes-based models, including those responses which support children, young people, families, adults and carers early.

This Royal Commission is an opportunity to listen and consider cross-sectorial advocacy, on behalf (and alongside) many families, individuals and community members, as well as heed collective calls for greater investment in early intervention for children, young people and whole of family services.

Whilst much of the Commission's work is future-focused, it is salient to remind ourselves that for many adults in state-funded treatment services or justice system, there were too many missed opportunities to respond early and effectively and change lives for the better. If this Royal Commission is to influence and compel much needed changes, it needs to build on and integrate the findings of the many Inquiries, reports (as well as the work of advocates) which have preceded it. This includes those findings of the *Victorian Government's Family Violence Royal Commission (2015)* and the *Commonwealth's Royal Commission into Institutional Child Sexual Abuse (2013)*. This Royal Commission should also acknowledge that many survivors of sexual assault/abuse, family violence, discrimination and hate crimes still risk further trauma and abuse in mental health systems.

The connective thread throughout these Inquiries has been the significant failure in State and institutional responses, including the lack of early responses, whether in terms of access to sustained and effective care, or safe, inclusive and joined-up supports. These Inquiries have also illustrated the need for systems which support families and carers and recognise families as 'the setting for prevention', instead of merely substitute or alternate care when tertiary or crisis care is the sole option or worse, not available.



It is also critically important for mental health services to span a spectrum of needs and offer interventions across a continuum, in recognition that recovery is personal, occurs over time, and cannot rely on a single, brief set of interventions that are only accessible when there is minimal choice or options.

As a long-term provider of community-based mental health support for adults, children and young people, we are hopeful the Commission will recognise the knowledge of lived experiences, alongside a broad range of community-based service and workforce expertise. We also encourage the Commission to examine perspectives beyond diagnostic, clinical models or views. This includes acknowledgement of the challenges and complexities of help-seeking, access, comorbid presentations, relapse and recovery and the need for affirming, support pathways in and out of systems to reconnect with community life.

Our agency's key focus for many years has been on early intervention and preventative whole-of-family mental health. This embodies our vision '*Promoting Wellbeing for Life*'. and our commitment to the provision of early in life, early in onset, supports across a full spectrum of mental health interventions; (and other interventions) known to improve mental health, wellbeing and the resilience of individuals and families.

Our family and community supports cross a spectrum of interventions which sit within a proportionate universalism framework to address common risk and protective factors. This reflects some of the stepped care/co-care models proposed by funders at State and Commonwealth levels. We believe it is vital at this juncture to assess funding models and assumptions at this juncture. This includes placing emphasis on the use of relevant and known evidence that applies life-course theory and situate it within asocial health determinants and public health framework.

drummond street services/queerspace welcomes the opportunity to work with the Victorian government to support mental health reforms and this Inquiry. This includes progressing the pressing concerns for many of our most vulnerable clients, carers and their families who desperately need change and reform.

I welcome further discussion on the work of my agency and work with the Commission, government and sector partners as part of important policy and program reform potential to improve the mental health and wellbeing outcomes for Victorians.

Yours sincerely



Karen Field
Chief Executive Officer
drummond street services/queerspace



Executive Summary

drummond street/queerspace believe a range of mental health supports with a focus on prevention and early intervention for whole of families should be provided across sectors; and as part of a whole of government interdepartmental public health response. This should target community needs across the lifespan with the goal to:

- reduce the prevalence of mental illness and poor mental health and associated risks to wellbeing and safety for adults and children
- reduce impacts and costs on the clinical system
- contribute to the effectiveness of clinical systems
- provide options to improve mental health outside the clinical system
- Address a range of social determinants to wellbeing that both drive poor mental health and result from mental ill health

This submission provides considerations of mental health support in the context of other interrelated issues, particularly trauma and co-morbidities.

It begins with a summary of the drummond street/queerspace approach, family inclusive engagement and the import of upstream interventions. We then examine a range of cohorts including children under 12, LGBTIQ+ communities, people who have experienced intimate partner and family violence (IPFV), trauma, adult survivors of child sexual abuse and carers. We also discuss potential harms in the system and the importance of peer workers.



Key Recommendations

Recommendation 1: *The Royal Commission process build in the technical capacity to undertake an independent, critical examination of international and local evidence to identify effective whole of family approaches to mental health; and identify promising outcomes in the prevention and early intervention of mental illness among children and youth.*

Recommendation 2: *Government fund and resource whole of family work prevention and early intervention programs which adopt broader community understandings and meanings attributed to poor family mental health; with the goal to address difficult behaviours in children through the strengthening of family relationships.*

Recommendation 3: *Government fund a range of initiatives ('for communities/by communities') to address the psychological impacts of stigma, discrimination and violence towards marginalised cohorts via targeted campaigns and public mental health promotion messaging.*

Recommendation 4: *Government include the impacts of trauma in wide reaching mental health campaigns, so the public and community organisations may identify post trauma and complex trauma symptoms earlier in efforts to reduce negative impacts on individuals, families, carers and communities.*

Recommendation 5: *Government implement a Victorian public model of health prevention and early intervention action plan for mental wellbeing to guide funded agencies to measure program objectives, initiatives, process, outputs and outcomes against the public health and wellbeing outcomes framework.*

Recommendation 6: *Government invest in the development of a **mental health and wellbeing early intervention workforce Strategy**.*

Recommendation 7: *Government invest in the development of a **Victorian public model of health prevention and early intervention Action Plan for Mental Wellbeing**. This should include strategies to improve data collection and address data gaps which compromise the monitoring of health inequalities among populations (e.g. CALD and LGBTIQ communities).*

Recommendation 8: *The Royal Commission explore ways to determine the efficacy of current child and youth mental health programs (including whole family outcomes) to better address social determinants of risk, identify a broader range of vulnerabilities and provide family inclusive interventions in a timely manner. Scrutiny should apply to how services are delivered, what is delivered and service relationship quality with families.*

Recommendation 9: *The Royal Commission examine Inquiry themes in ways which:*

- *are consistent with the Victorian public health policy agenda;*
- *avoid the siloing of co-morbidities and;*
place importance upon evidence informed programs, processes and practices as identified in the development of the Roadmap to Reform



Recommendation 10: Government provide investment for research to expand knowledge of the relationship between known risk and protective factors to mental health and the wellbeing of LGBTIQ+ communities (such as a trial of an 'LGBTIQ communities screening and Outcome Tool').

Recommendation 11: Government fund trials of clinical interventions which can address both **common** and **unique** risk and protective factors for mental health of each LGBTIQ+ cohort.

Recommendation 12: Government fund specialist parenting and family support services for LGBTIQ+ communities and expand capacity for existing LGBTIQ+ peer support models within clinical interventions to address increased social isolation.

Recommendation 13: The Royal Commission explore ways to create new and improved systems, policy, operational and funding arrangements which complement the complex trust needs; and long-term health and wellbeing issues of ASCSA survivors and their families. Any strategies to improve systems, policy, operational and funding should factor staff turnover, and a lack of organisational and program stability as a significant barrier to ASCSA and their families accessing mental health services and supports.

Recommendation 14: Government invest in services for family and carers of ASCSA to assist them with psychological, physical and social wellbeing. Services could include counselling, psychosocial education and support groups, assessment, planning, respite options and advocacy to assist carers in identifying their needs and increase their capacity to support and maintain healthy relationships with their loved ones.

Recommendation 15: The Royal Commission explicitly refer to examination of a means to identify the level to which reported incidences of violence, abuse, neglect by services breach the threshold of human rights, duty of care quality and compliance and other legislated Criminal Law; and, whether reporting mechanisms ensure such determinations can be made.

Recommendation 16: The Royal Commission into Victoria's Mental Health System undertake a review and analysis of current collaborative jurisdictional policy and investments to include and ensure a public health response to risk factors of poor mental health is coordinated appropriately.

Recommendation 17: Government invest in recovery-oriented service models and programs that place emphasis on building a lived experience workforce to address the lifelong needs of complex trauma survivors, their families and carers. These models and programs should span a range of sectors which come in regular contact with clients experiencing complex trauma; and engage communities who face barriers to service access and employment such as LGBTIQ+, people with refugee backgrounds and people with a disability.

Recommendation 18: Government improve access to mental health, related services and family/carer supports as per recommendations by Carers Victoria and Tandem identified in this submission.

Recommendation 19: Government provide more information and resources on the Royal Commission processes that target participants, their families and carers; and, release funding for agencies working closely with participants in this Royal Commission so their families/carers have increased capacity to advocate for and/or access emotional supports during the life of the Inquiry.



About drummond street

drummond street services is a 130+-year-old, non-denominational, not-for-profit organisation that provides services across the North Western regions of Melbourne and Geelong. These include a range of specialist child, youth and adult mental health services and targeted family programs for LGBTIQ+, First Nations, migrant and refugee communities. We provide integrated whole-of-family support through our funding across all levels of government.

drummond street works closely with State and Commonwealth services across mental health including promotion, prevention, early intervention, primary, specialist mental health, emergency and crisis services. drummond street's public health aspirations and specialist practice knowledge has resulted in close working relationships with both universal and tertiary-end services, organisations and agencies who either have contact with, or act as gateways for highly vulnerable families.

drummond street's health and human services delivery and sector capacity-building work extends nationwide through our Stepfamilies Australia national office; and our Centre for Family Research and Evaluation (CFRE) which works closely with a range of university partners.

Our queerspace service is the first federally funded (and largest Victorian provider) of LGBTIQ+ community specialist mental health services, along with our lead role in 'w|respect' LGBTIQ+ family violence service. queerspace provides supports for individuals, families, children and young people. We work to the principle 'for community/by community and are committed to partnerships with a range of grassroots LGBTIQ+ capacity building organisations.

Over the past decade drummond street/queerspace has been at the forefront of developing innovative responses to marginalised populations with complex trauma histories. These populations include children and adults with experiences of intimate partner/ family violence (IPFV) and sexual assault, refugee and humanitarian entrants, whole families where mental illness and comorbidities are present and institutional child sexual abuse victims.

We apply a public health approach and a social health determinants lens which underpins all of what we do. Using population-based, social health data and common life-course risk and protective factors across multiple wellbeing domains to map community needs and address negative preventable outcomes ⁽¹⁾ for our clients.

drummond street's work in mental health

drummond street/queerspace offer a range of no-cost (or low cost) services that promote health and wellbeing within families – with a particular focus on the needs of children and young people. Our work aims to:

- Reduce prevalence of mental health burden
- Address early risks of poor mental health outcomes

1 Program Planning and Evaluation: how to use evidence to support Communities for Children's services drummond street services and Deakin University, 2016, Program and Planning and Evaluation p. 10 cites Toumbourou, J. (2015)



- Support families to access assistance, create and maintain positive family and parent-child relationships and home environments
- Support children and young people's emotional wellbeing through pro-social, positive connections with family members, school and the wider community

Our community-based, family and community services are integrated with our mental health clinical therapeutic and support services and delivered through:

- **Parenting and Community Support Programs:** Delivered at our service sites across North-Western Regional Melbourne and Geelong, outreach into communities i.e. early childhood Centre's, Maternal & Child Health Centres, schools, housing estates and other community locations.
- **Centralised, Whole-of-Family Intake, Information Referral and Brief Support Service:** Phone and face-to-face intake, triage and risk assessment service for those seeking support or concerned about their child or a family members wellbeing. Offering assessment, mental health information; and brief parenting, relationship and family support Integrated support or supportive pathway into other community or treatment services is provided.
- **Intensive Family Support and Counselling Services:** Whole-of family support for those presenting with children/young people with multiple wellbeing risks. This includes case management, psychological, clinical and trauma treatment, child/adolescent counselling, family-based counselling/therapy and/or couples/parenting education.

We support people with chronic and debilitating mental health conditions as a core part of our work. drummond street/queerspace undertakes integrated, pro-active advocacy and co-planning with Area Mental Health Services, clinicians, CATT, CAMHS, emergency services, Prevention/Recovery Centres and acute psychiatric wards and mental health service networks. We provide centralised intake, triage services and trauma-informed/recovery-orientated support planning which includes carers and families in case management, emergency planning and referral. Our practice ensures we assess every client's current/historical risks, co-morbidities; i.e. substance misuse, physical health and psychosocial functioning to identify support needs, and design self-management and treatment and recovery strategies.

Other complex service responses drummond street/queerspace undertake include supports for women and young people who have experienced/or use violence, supports for LGBTIQ+ people at high risk of harm/self-harm, case management for refugee and humanitarian entrants and whole-of-family work where mental illness and comorbidities are present.

drummond street/queerspace is committed to ongoing practice fidelity and measurable outcomes, with all programs subject to pre/post outcomes evaluations using mixed-methods including: process evaluation across new innovative or evidence-based programs, qualitative interviews, focus groups and validated pre/post intervention outcome measures. We are committed to co-design, co-production and consumer engagement, working collaboratively with mental health carer, consumer peak bodies, peer support workers, clients/families and researchers to design or participate in our service, governance and evaluation instruments.



Our support to LGBTIQ+ communities

drummond street/queerspace services targeting LGBTIQ+ communities span a spectrum of integrated offerings that respond to a range of comorbid presentations, alongside mental health issues. Many of these services intersect with tertiary end mental health services, including:

- Sexuality and gender counselling and support
- Mental health and alcohol and other drug (AOD) counselling
- Whole-of-family mental health, trauma informed early intervention and treatment services (psychological treatment; recovery support; acute mental health care co-ordination; case management; suicide after-care and post intervention support)
- Queer relationship, parenting support programs and youth services
- State wide w|respect LGBTIQ+ specialist integrated family and intimate partner violence (FVIPV) services including a state-wide intake, after hours telephone line, FVIPV sector secondary consultation service, identification and responses for adult and child-youth victim survivors and perpetrator programs
- Trans and Gender Diverse (TGD) support services including case work to access legal services, social transition support, support in early childhood centres, education settings and workplaces
- Housing and homelessness support
- Peer led programs with psychosocial support elements addressing health, social isolation and capacity building.

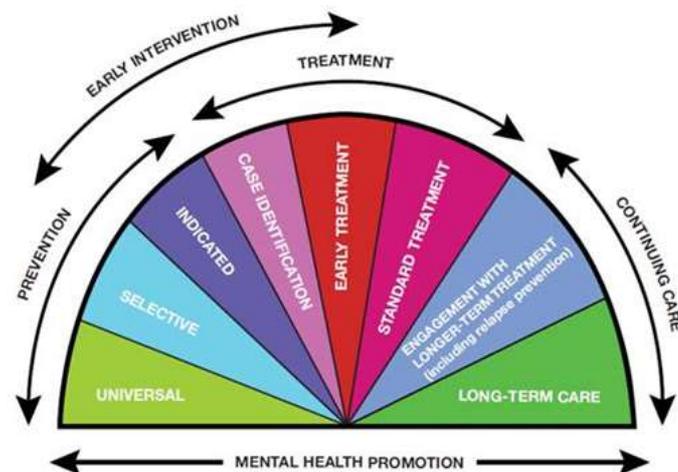


A spectrum of early mental health interventions and prevention is key

drummond street/queerspace believes much more can be done to expand mental illness prevention, early intervention and mental health care models within State government jurisdictional responsibilities. In particular, models and programs that are oriented and resourced beyond just clinical, diagnostic and acute individual services. Increased investments are needed for more community-based services that establish, or are connected to existing universal support platforms within communities, to ensure better access, cultural appropriateness and reduce stigmatising responses for families across the life course.

Prevention and early Intervention needs to address multiple risk to family wellbeing and respond in universal and targeted ways.

As identified by Toumbourou et. al, ¹ ‘prevention’ refers to initiatives that avoid or delay the onset or severity of health, mental health, or social problems. A comprehensive, integrated service response system to mental health requires investment and resourcing across a ‘spectrum of interventions’ with the greatest funding required in prevention and early intervention. These can be universal, applying to an entire population (National populations); selective, to target those groups and cohorts with elevated risks (such as First Nations peoples, LGBTIQ+ communities and refugee populations); and Indicated, targeting support for individuals already showing signs or symptoms of problems.



Funding investments, supported by policy and planning should drive resourcing into communities where community and social health data shows socio-economic, developmental vulnerabilities within local populations; and, work in concert within other platforms. Service gaps and integration opportunities also need to inform appropriate and equitable service design as part of broader planning.

A foundational document produced almost two decades ago, by the Australian Government National Mental Health Strategy (2000), *Promotion, Prevention and Early Intervention for Mental Health Monograph* outlined key elements, widely accepted by mental health practitioners and researchers that contribute to the development of mental health problems and illness (²). Building on the work by Fuller and McGraw (1996), and Blum and Resnick (1996) it described a common set of risk and protective factors to multiple dangers to health including: mental illness; alcohol and other drug



(AOD) abuse; violence; anti-social behaviour; crime and offending; school disengagement; and youth pregnancy. Similarly, a 2017 report on Prevention and Early Intervention Services for families identified these risks to wellbeing in addition to obesity, developmental injury, chronic illness and social exclusion ⁽³⁾.

Although significant many of these risk factors are modifiable, but only with the right investments; and, if government and primary allied health and social services work together and listen to communities. These common family wellbeing risk and protective factors have been clearly identified as priority areas for intervention. They are key to both the development and funding of strategies that can not only enhance children's mental health and wellbeing but turn the curve upwards in improving lifetime mental health outcomes.

Saving costs upstream by applying a public health framework to mental health in Victoria

"A public health approach, by definition ... aims to provide the maximum benefit for the largest number of people ... the concern is to prevent health problems and to extend better care and safety to entire populations ... (This approach) is interdisciplinary and science-based ... It emphasises collective action ... cooperative efforts from diverse sectors ... is above all characterised by its emphasis on prevention". ⁽⁴⁾.

In using a public health approach to improve the Victorian mental health system, investment and resourcing of both 'upstream' (preventative measures), and 'downstream' (rescue/crisis measures) makes both good public health and economic policy sense. Prioritising prevention investment - before impacts for individual adults and children, their families and the broader community become entrenched and severe - can reduce the significant disease and economic burden. The costs to the community are significant, (all preventable and modifiable) estimated at over \$8.5 b p.a. in mental health costs, \$55 b in substance abuse; anti-social behaviour (violence and crime costing \$36 b and family violence \$26 b (FRSA Toubourou et al).

Marmot (2010) '*Fair Society Healthy Lives*' talks to policy and funding settings that address the social determinants of health; and, acknowledges the unequal health disparities experienced by those vulnerable and marginalised groups in the community, such as social-economic disadvantage, poverty, neglect, unemployment and homelessness ⁽⁵⁾. All these disparities drive and exacerbate poor mental health. Marmot also argues for a *Proportionate Universalist* approach; i.e. a universal platform for whole communities, with differential interventions of variable levels of intensity (or dose) based on risks and levels of need.

Evidence and practice tell us many health and social problems have common foundations in experiences across the family life course. Using a developmental or life course approach, we can see how risk and protective factors can be arranged across time, particularly at key life transitions; i.e. parenthood, child commencing school, adolescence, family formation, separation etc. These factors emerge at different developmental or family life course stages and can accumulate over time. For those individuals and families already experiencing increased stress and vulnerabilities, it also increases their risk of poor health and wellbeing outcomes, including mental health.

Years of research also tell us of the critical importance of the caregiving environment (including the health of parents, healthy family relationship dynamics and healthy parenting practices) during pregnancy and the early years, and to support brain development and the long-term wellbeing of



infants, children and adolescents. Research also indicates the impact a family member's health and wellbeing can have on other family members. For instance, a strong predictor of a child's mental health is their parents having a mental health condition. Again, Marmot (2010) confirms the influence of parenting or caring on early child development, which conversely influenced the circumstances in which the parenting or caring takes place. Mental health investment must acknowledge the role in supporting all families, particularly at key life transitions as part of a whole of Government Victorian mental health prevention and early intervention plan, if we are serious in the mental health and wellbeing of children and young people.

drummond street/queerspace notes both the Commonwealth and States have been historically reluctant to relocate expenditure away from acute/crisis services due to unclear dichotomy between community and hospital-based services, including the role of hospitals in the management of community based clinical mental health services (6). drummond street/queerspace believe there is a case, and an opportunity, for State mental health services to be more family focused, as well as incorporating the use of mental health outcomes measurements within a range of other sectors program reporting to monitor the impacts of a wider range of mental health and wellbeing risks to vulnerable families.

Table 1

Prevention Intervention type	Target Group	Aim/Programmes	Example
Universal	Whole population not identified based on individual risk	Improve population mental health via mental health promotion	Perinatal mental health Three-year-old social and emotional well-being health check
Selective	Individuals with a significantly higher risk of developing a mental disorder due to biological, psychological or social risk factors. This includes vulnerable life course transitions (e.g. primary and secondary school transition, transition to parenthood and post separation) and specific subpopulations/ cohorts (e.g. refugees, ATSI, LGBTIQ+)	Reduce identifiable risk and augment protective factors	Support around trauma related issues for refugee humanitarian entrants Family/emotional support for families with a gender diverse child Support for children post separation Health promotion in schools in the middle years
Indicated	Children identified as having signs or symptoms of a mental health problem or experiencing circumstances which are a risk to their wellbeing.	Evidence based early interventions	Whole of family and wellbeing support services to support child needs where IPFV has occurred or where a parent experiences mental illness (counselling and case management services, advocacy around service access and coordination).



Family inclusive engagement with children under 12 means upstream capture

drummond street/queerspace recommends the Royal Commission examine a full range of mental health support models to address the increasing growth in childhood mental illness, and early onset of mental ill health symptoms and risk. Mental illness in adults often originates in childhood and adolescence. Half of all lifetime cases of mental health disorders start by age 14 years and three quarters by age 24 years ⁽⁷⁾ with onset peaking between 12 and 24 years ⁽⁸⁾. While investment in youth mental health is important, prevention and early intervention investments for early in life are unfortunately limited.

We believe initiatives targeted to groups who access clinical services at lower rates than the National average, such as Victorian children ⁽⁹⁾ are especially needed. This includes in particular whole of family early interventions that address the mental health needs of children aged 0 -12 years. The National Mental Health Commission 2018 report also identifies 0 – 12yrs as a critical gap which requires local and integrated community action to ensure healthy child development and wellbeing, ⁽¹⁰⁾ including the provision of necessary supports for primary care givers.

Additionally, the prevalence of mental disorders increases with decreasing levels of family functioning ⁽¹¹⁾, and there is overwhelming evidence of risk and protective factors to mental health residing in the family setting; including evidence of the effectiveness of family/parenting interventions to address child/adolescent mental health needs.

An analysis of data from the Longitudinal Study of Australian Children (LSAC) found amongst risk factors predisposing children to mental illness in adulthood, those that were family based were highly prevalent ⁽¹²⁾. For example, between the ages of 2-9 years, hostile/angry or overprotective parenting was experienced by more than one in five children and between 10-13 years, and the two most prevalent risk factors were parenting that was low in warmth or frequently hostile or angry. Additionally, across childhood, one in seven children were in families exposed to 3 or more major life stressors ⁽¹³⁾.

This reflects our own data for our family mental health and support services. Overall our programs had high rates of child social and emotional wellbeing difficulties presenting at first session. drummond street's programs showed overall levels of mental health distress at 83%, whilst our family and child mental health were at 87% at baseline. We use the Strengths and Difficulties Questionnaire (SDQ) to measure a child and young persons wellbeing, as reported by either the parent/carer or the young person. The SDQ measures: emotional symptoms, conduct problems, peer relationship problems, hyperactivity/inattention and pro-social behaviour and is aggregated across the age ranges; 0- 4, 5-10 and 11-17yrs.

We found baseline difficulties in emotional symptoms, hyperactivity, and peer relationship problems increased across the age categories between ages 2 – 17 yrs for those children accessing our family programs. Alarming, 77% of parents and carer evaluation respondents also noted these issues had existed over 12 months before accessing help. Overall, 72% of children under 11yrs had symptoms of social and emotional wellbeing difficulties at their initial session.

Of significance too was our results demonstrated *children in the 5-10yrs* age group showed a significant correlation (moderate in size) between adult and child mental health/wellbeing and demonstrates the importance of whole of family service provision at this specific age group. In our



examinations of relationships between child SDQ scores and parents' presenting needs, risk factors and risk alerts, parent and carer issues were significantly correlated with total child SDQ scores only in the 5-10 age group. Presenting needs, risk factors and risk alerts were related to a series of difference SDQ subscales, where 37 significant correlations were identified. For example, we found child protection involvement showed significant correlations to peer relationship problems, and poor parental mental health showed significant correlations to hyperactivity, peer relationship problems and low prosocial behaviour.

Currently there are limited Commonwealth and State Governments investments responding to this evidence in an integrated manner. Despite family settings or key life transitions playing a significant role in predicting the mental health outcomes of a child ⁽¹⁴⁾ families often remain excluded in the medical and psychiatric care and treatment matrix. There is also little conceptualisation of how families fit services into their lives, nor the impact of stigma, particularly for children, in service access on help seeking choices.

Recommendation 3 from the *'Investing to Save'* report, also confirms this, where it identified prioritising at-risk groups is a valuable starting point for focused early intervention investments ⁽¹⁵⁾, especially for children in vulnerable families and communities ⁽¹⁶⁾. We note too, improvement of early identification of mental illness through strategic service integration that targets whole families would also complement priorities of the Victorian public health and wellbeing Action Plan ⁽¹⁷⁾.

It is clear the role of parenting, home and care environments are at the core of early-onset problem behaviour and adjustment problems and are integral to the solution ⁽¹⁸⁾. This is contrary to interventions that target at risk children within an individual psychological treatment framework, without considering wider contexts where issues can arise.

Despite growing interest in youth mental health models, the current orientation of funding and delivery remains limited to centre-based care, private practice psychological workforces and predominantly individualized, clinical approaches. We believe there remains an over-reliance by both the State and Commonwealth on applying adult clinical models to children and young people, without supporting their family environments or parental/caring relationships in a holistic manner.

In Victoria for example, child and adolescent (0 – 18yrs) mental health services (CAMHS) and adult (16 – 64yrs) mental health services (AMHS) provide treatment to young people requiring ongoing specialist mental health care. Service components of both CAMHS and AMHS (including case management) are mainly limited to addressing serious mental health issues and emotional disturbance among children, rather than prevention, identification, mitigation of, or early treatment of a child's symptoms of poor mental health. This is compounded by limitations in access to case management and family supports provided by Headspace which do not target children 0-12yrs.

Similarly, family support programs with any child mental health functions are inconsistent in eligibility and service continuity. For example, Early Parenting Centre Services provide assessment of infant mental health in Victoria but are limited in the services they can offer, as well as being only for families with children from pregnancy to 4 years of age.

Another example of oversight in this area is the PHN's flexible funding pool which was set up to support the planning and commissioning of primary prevention using a stepped care model. This model outlines what needs to be achieved for consumers and which services may achieve these



objectives. It is a striking omission that the ‘family setting’ is absent from the stepped care model, especially in relation to child and adolescent mental health.

Subsequently drummond street/queerspace have advocated for increased Commonwealth investment in whole-of-family, wrap-around case support and group programs for those accessing or seeking Federally funded primary and mental health programs. This includes investments to cover administration costs incurred linking people with PHN’s allied health stepped care services.

drummond street/queerspace’s long-standing practice focus has been in prevention-early intervention which is informed by evidence. We place a strong emphasis in the development of programmatic responses based on identification and response to early onset, risks. We work with, and are supportive of local, community-based universal services to deliver connected, integrated, holistic, wrap-around support that focuses on whole-of-family and puts women and children’s safety first. By whole of family we include both parents and child/-ren, siblings, extended families (co-parenting, shared parenting or restoration of parenting). We would like to see more of this approach and type of services in Victoria.

Recommendation 1: *The Royal Commission process build in the technical capacity to undertake an independent, critical examination of international and local evidence to identify effective whole of family approaches to mental health; and identify promising outcomes in the prevention and early intervention of mental illness among children and youth.*

A family mental health focus means less stigma around mental illness in children and adults

Many campaigns address stigma around mental illness. However, drummond street/queerspace believes a greater understanding of the risk and protective factors to mental health; and factors which exacerbate existing mental illness are important to educate communities about. While recovery principles are better understood in clinical and (some) health promotion settings and campaigns, these usually apply to fixed diagnostic category contexts. Furthermore, a vast majority of investment in primary prevention has targeted schools with little to no effect. Given the significant evidence of families and parenting as a setting for interventions there is not enough investment in parental social, emotional well-being; and to programs that build parent capacity to raise resilient children.

Message around trauma: putting mental ill health in context

Trauma recovery and social determinants of poorer wellbeing are not often included in the framing of public mental health messages and could be better incorporated, particularly in ways which empower people *beyond help seeking into helping themselves*.

drummond street/queerspace believe an increase in community awareness about the impacts of trauma would be useful to help people put mental wellbeing into context. In particular, how trauma manifests and can arise episodically over people’s lives and impact physical health. For



example, campaigns about trauma impacts, post-traumatic stress and complex trauma and how to identify and address trauma related symptoms that support emotional and physical recovery.

Mental health education campaigns could target victims of crime and communities impacted by natural or climate change induced disasters to highlight vulnerabilities to people's wellbeing, bringing awareness to how people's thoughts, perceptions or behaviours can change after significant shocking events. Campaigns could also target whole communities at higher risk of discrimination or violence (for e.g. due to faith, ethnicity, race, culture or LGBTIQ+ status).

The increased vulnerability of trauma survivors as they navigate common life course transitions, demonstrates the ongoing nature of complex trauma experienced across their lifespans. This is contrary to the view and expectation of a psychological treatment model (on its own, post crisis and brief in nature) for complex trauma. For example, the view that after an episode of effective treatment service/intervention and "the problem is fixed" the intervention is no longer needed. Many survivors often speak of the failure this fosters. Rather they need to free themselves from the "tyranny of expectation of being fixed", towards defining what recovery looks like for them and learning to "live with" the expected additional vulnerabilities resultant from complex trauma histories.

Work with whole families on multiple issues

Parents who attend drummond street/queerspace programs can often be reluctant to ascribe a mental health diagnosis to their child. Likewise, culturally diverse understandings of mental illness can diverge from anglo-centric or psychiatric categorisations. This stigma and inappropriate pathologisation, can be avoided by working with whole families earlier in prevention and early intervention settings to validate and 'normalise' experiences or to accelerate assistance where appropriate.

Many families we work with experience issues with more than one child, and their identification of priorities, does not always lead directly to a child with poor mental health. For example, there may be a child with an intellectual disability who requires respite, another child with conduct issues, alongside other family stressors which contribute to poor interpersonal dynamics between the parents and children. Parents may prefer to focus on supports which address the child with an intellectual disability to reduce stressors and improve interpersonal dynamics within the whole family thereby improving behaviours in the other child with poor conduct. Many parents may need support beyond the period to which early parenting services are offered and/or not feel comfortable with services that are linked to child protection.



Recommendation 2: Government fund and resource whole of family work prevention and early intervention programs which adopt broader community understandings and meanings attributed to poor family mental health; with the goal to address difficult behaviours in children through the strengthening of family relationships.

Recommendation 3: Government fund a range of initiatives ('for communities/by communities') to address the psychological impacts of stigma, discrimination and violence towards marginalised cohorts via targeted campaigns and public mental health promotion messaging.

Recommendation 4: Government include the impacts of trauma in wide reaching mental health campaigns, so the public and community organisations may identify post trauma and complex trauma symptoms earlier in efforts to reduce negative impacts on individuals, families, carers and communities.

Public health and related policy contexts in Victoria

drummond street/queerspace notes the life course approach captured in the *Victorian Public Health and Wellbeing Plan (2015 – 2019)*. We welcomed the development of the Plan since commencement in 2011 and the subsequent Plan's strategic directions in mental health. In particular, those which support investments in early identification and interventions with vulnerable families, children and targeted action for those who experience greater social and economic disadvantages.

We are pleased to see the Plan's strategic directions have guided investments in some Place Based approaches which can establish gateways to universal and some demographically targeted services in Victoria. We do not however see equitable benefit of these approaches for marginalized cohorts who find trusting mainstream services difficult, have insufficient or absent data collected on them, or who due to disadvantage are transient, and/or exist in small communities which may result in them seeking services beyond their area.

drummond street/queerspace remains firm on the need for a diverse service mix of place-based universal services to occur alongside selective and indicated targeted services which are designed, produced and implemented by and for cohort communities that experience higher risks to wellbeing. We believe this is key to genuinely respond to the intersectionality of peoples lived experiences.

drummond street/queerspace also notes, outcome measures for the *Victorian Public Health and Wellbeing Plan (2015 – 2019)*, and the outcomes framework, record disease prevalence, healthy behaviours, social inclusion measures and rates around risky behaviours. The relevant service providers have the capacity to produce data and should undertake data collection and analysis including baseline data, social determinants, fidelity to practice models and service outcomes. This would identify potential areas for innovation, and is an opportunity to continue to build an evidence based of our local mental health systems



We would like to advocate for the development of sector capacity to undertake data collection, and the common use and application of data; particularly on prevention and early intervention activities and programs. We would also like to see the development of the next Plan explore measurement of the impacts and reach of prevention and early intervention activities.

We urge the Royal Commission to examine how the State Government could use evidence, improve outcome commissioning and drive increased and innovative use of data to review programs (including fidelity data, and measuring the use of and upscaling of evidenced informed-based interventions with a focus on prevention and early intervention). We also believe Government needs to recognise the unique skillsets of prevention and early intervention workforces.

drummond street/queerspace would welcome scoping and consultations for the design of a **comprehensive public model of health prevention and early intervention action plan for mental wellbeing** which could guide agencies to measure objectives, initiatives, process, outputs and outcomes against a Public Health and Wellbeing Outcomes Framework.

This action plan should also seek to address gaps in data collection that compromise the monitoring of health inequalities for at risk populations (e.g. CALD and LGBTIQ communities). We recommend this includes a mental health and wellbeing early intervention and prevention workforce strategy; and is complemented by a commitment to invest in a mental health prevention and early intervention workforce.

Recommendation 5: Government implement a Victorian public model of health prevention and early intervention action plan for mental wellbeing to guide funded agencies to measure program objectives, initiatives, process, outputs and outcomes against the public health and wellbeing outcomes framework.

Recommendation 6: Government invest in the development of a **mental health and wellbeing early intervention workforce Strategy**.

Recommendation 7: Government invest in the development of a **Victorian public model of health prevention and early intervention Action Plan for Mental Wellbeing**. This should include strategies to improve data collection and address data gaps which compromise the monitoring of health inequalities among populations (e.g. CALD and LGBTIQ communities).

The cause and effect circle for those at higher risks to poor mental health

drummond street/queerspace note the Commission's Terms of Reference stipulate the conduct of the Royal Commission pay regard to the Productivity Commission's Review into Mental Health. We believe the assessment approach of the Productivity Commission⁽¹⁹⁾ examines only a portion of what Governments need to know to fully consider the issues and ideas for change.

For instance, what are perceived as the consequences of poor mental health in the Inquiry discussion paper are frequently driven by other causes such as discrimination due to personal characteristics (e.g. Aboriginality, cultural or faith diversity, gender identity or sexual orientation) which correlate



with poor mental health outcomes. We believe this should be factored into the Productivity Commission's assessment approach.

Through our work drummond street/queerspace are keenly aware of the significant psychological impacts of experiences which intersect with mental illness among our LGBTIQ+ clients and youth. For example, racism can impact people's mental health and increase risks to mental illness⁽²⁰⁾. This creates compounded impacts; e.g. those due to racism (disadvantage and discrimination), and those due to the poor mental health resulting from racism (further disadvantage and discrimination).

Likewise, we support and refer the Royal Commission to key recommendations in a submission to this Inquiry by the Australian Federation of Disability Organisations (AFDO), Disability Resource Centre (DRC), Disability Justice Australia (DJA), Women's Mental Health Network Victoria Inc. (WMHNV) and Women with Disabilities Victoria (WDV) who identify the need to address high rates of mental illness and trauma arising from discrimination and violence experienced by people with disabilities. Their submission discusses the importance of centering the lived experience of disability in discussions of prevention, early intervention and systemic change to improve wellbeing outcomes among people with a disability.

Where programs target marginalised communities, who face other multiple and compounding risks, it is important Government funds evaluative components in order to determine the best specific and targeted responses to specific cohorts.

When marginalised and vulnerable cohorts are examined beside a cost analysis of poor mental health in the community, it is essential to do so alongside recognition of the drivers of disadvantage and risks to wellbeing which lie beyond the scope of the mental health system to fix. In turn, it is also necessary to assess how responses to distress, trauma and adversity may act as a preventative mechanism to reduce prevalence/or the exacerbation of mental illness. We would like to see a system which can work beyond co-morbidity siloing, so marginalised groups can receive better support.

This would greatly assist access to services for a range of populations. For instance, there can be increasing complexity of defining mental illness among Aboriginal and Torres Strait Islander peoples where mental disorders associated with harmful substance use are identified. This leads to problems in diagnostic systems where the two entities (substance use/mental illness) are often separated. There are also issues of accuracy in diagnosis where people may have specific needs in respect of grief or loss and the Stolen Generations⁽²¹⁾.

However, it remains that most service design for specific cohorts is based on limited data or developed using evidence regarding other populations, despite very specific needs which can impact both service design, delivery and client relationship with a service. Through our queerspace service and the design of a LGBTIQ mental health carer support program we know how narrow categories in tick boxes do not always obviously mirror a person's lived experience and the complexity of relationships.

For instance, some clients identifying as lesbian at our service are in long term relationships with transgender men. Therefore, information provided to carer support groups must include mental health consumer advocacy information reflective of these experiences. For example, regarding



safety in wards where ‘women only spaces’ are not appropriate for transmen consumers lesbian mental health carers may be supporting.

Alert to family violence risks

Risk factors contributing to poor mental health in childhood are similar to those underpinning adult mental health risks, including parenting and family issues. The leading risk factor contributing to disease burden among 0 -14-years age group for both males and females was child abuse and neglect⁽²²⁾. Child abuse, neglect, family relationship conflict and violence are key family risk factors identified as a priority health and social problem which need to be addressed by early interventions⁽²³⁾.

drummond street/queerspace welcomed Victorian Government policy and investments which have the goal to support children learning, healthy child development and build capabilities among parents to ensure children are safe and raised in resilient families. For example, those emerging from recommendations of the *Royal Commission into Family Violence*; and the Government’s subsequent response and initiatives flowing from the *Roadmap for Reform: safe children; strong families strategy* and the *Early Childhood Reform Plan* which includes The Early Years Compact between state and local governments.

drummond street/queerspace notes the Terms of Reference section beneath Inquiry Conduct ‘h’ which states the Royal Commission pays ‘regard to changes to laws, policies, practices and systems as a result of the Royal Commission into Family Violence’, including changes intended to facilitate easier navigation of Victoria’s justice and social services and ‘better enable service providers to share information and interfaces between services for people with multiple needs’⁽²⁴⁾.

On this matter we refer to recommendations made in an evidence review informing the ‘Roadmap to Reform’. This review found ‘more attention needs to be paid to the development of high-quality relationships between professionals and children, young people and their families’⁽²⁵⁾. In addition, as part of this evidence review the Centre for Community and Child Health examined research which is useful to those seeking to address issues of poor mental health in children.

This Royal Commission is an opportunity to look beyond mental health settings and establish multilateral efforts across a range of sectors and portfolios that interact with clients who access the mental health system, require mental health supports and who are at risk of experiencing poor mental health over the life course. There are few long-term mental health and wellbeing service offerings for children who are either already experiencing or at risk of experiencing poor mental health which identify, quantify and address the psychological impacts of existing or past experiences of IPV. This is contrary to emergent policy directions occurring outside of mental health system.

LGBTIQ+ communities and queerspace data

drummond street/queerspace is an innovative service leader in the provision of programs across the lifespan for LGBTIQ+ communities, including sex and gender diverse children/young people, LGBTIQ+ people experiencing homelessness, disability and/or chronic illness.



Consistently, a significant number of presenting needs across queerspace (individual and family) services include mental health, self-harm and suicide. Our service responses include psychological treatment (Commonwealth funded TPS/Better Access), casework, advocacy, discharge planning and collaborative recovery-aftercare with acute mental health services and families.

Many of our LGBTIQ+ adult clients seeking mental health support present with much a higher risk than the Better Access/TPS program aims to support. However, for LGBTIQ+ clients there are very few specialist, affirming, mental health supports. Comparatively to all drummond street clients, queerspace clients possess higher rates of Financial Distress, Social Isolation and Mental Health Distress (see Table 2 below).

Table 2

	All ds Clients	queerspace Clients
Financial Distress	56%	65%
Social Isolation	35%	40%
Mental Health Distress	83%	90%

Evidence connecting the experience of sustained discrimination, violence, harassment and poorer mental health outcomes for LGBTIQ+ populations is growing, reflected in our own client pre-post outcomes data (26). A Royal Australian and New Zealand College of Psychiatrists (RANZCP) study also confirms the disproportionate number of LGBTIQ+ people experiencing mental illness and psychological distress (27). This is coupled with an increased risk of exposure to institutionalised and interpersonal discrimination and marginalisation, which in turn increases vulnerabilities.

Whilst this submission speaks in broad terms, drummond street/queerspace knows the import of understanding how discrimination related to sexual and gender identity (or expression) varies. Discrimination regarding sexual and gender diversities may intersect with non-LGBT related marginalities. Therefore, different LGBTIQ+ cohorts can have very different mental health and wellbeing outcomes. While further research across these variables and identities is emerging, more research and data collection is required to build on existing knowledge about specific cohort experiences and needs. We have found variable and increased rates of Mental Health distress, Social Isolation and financial distress on all our analysis of baseline measurements among our LGBTIQ+ cohorts. (See Table 5 and 6)

A recent community survey conducted by our queerspace service (28) with a sample of over 800 people indicated a high demand for mental health services, including services to assist families and carers.

Almost two thirds of respondents (63 %) stated they accessed a mental health service, with 49% accessing multiple mental health related services (see Table 4). Of those, most had sought initial help from a GP (largely public service GP's). Trans people were most likely to have accessed mental health services (65 %). Additionally, 64% of cis women in the community also sought such help. Carers made up one fifth of survey respondents, with 43% reporting they cared for someone with a mental health condition.



There were also high levels of disadvantage and wellbeing risks, with 25.4% of total respondents experiencing financial hardship, with 59 % of trans women experiencing highest levels of financial hardship.

Table 4 Total Respondents (queerspace 2019 Midsumma community survey)

	Accessed Service	Did not access this service
Mental health-related services provided by a GP	58.63% 462	44.16% 348
Mental Health Triage	17.64% 136	83.27% 642
Mental health-related services in general hospital emergency departments (public hospital)	15.22% 118	85.55% 663
Public inpatient psychiatric ward	9.95% 77	90.57% 701
Area mental health services (govt. funded and operated)	23.58% 183	77.45% 601
Crisis or mobile assessment and treatment services	10.88% 84	89.38% 690
Outreach services	10.95% 84	89.44% 686
Medicare-subsidised mental health-related allied health services	44.94% 351	57.62% 450
Residential mental health care (e.g. Prevention and Recovery Centre (PARC))	4.42% 34	95.58% 736
Government operated residential mental health care services	6.34% 49	93.79% 725
Non-government operated residential mental health care services	8.01% 62	92.12% 713
Services to support homeless people (RDNS homelessness outreach)	4.68% 36	95.71% 736
Community mental health support services	22.74% 176	78.68% 609

Table 5 Statistics of distress and isolation among different cohorts by sexuality

	Lesbian	Bisexual	Gay	Heterosexual	Pansexual	Queer	Questioning
Mental Health Distress	90%	91%	93%	82%	87%	88%	93%
Social Isolation	42%	34%	48%	33%	60%	28%	60%
Financial Distress	50%	77%	67%	51%	80%	62%	78%



Table 6 Statistics of distress and isolation among different cohorts by gender

	Cis Woman	Cis Man	Non-Binary	Trans Woman	Trans Man
Mental Health Distress	84%	83%	86%	95%	86%
Social Isolation	33%	37%	32%	29%	30%
Financial Distress	55%	50%	82%	75%	67%

Anxiety and Depression Risk and Protective Factors

Due to the lack of local LGBTIQ mental health research, drummond street conducted a research project, funded by Beyond Blue ‘*Building the Evidence Base; Risk and Protective Factors in the LGBTQ Community*’²⁹. Based on an in-depth clinical file audit of non-heterosexual clients, 18+ years over a three-year period, we were able to examine common risk and protective factors that have an impact on an individual’s mental health and wellbeing.

Unsurprisingly, the audit findings highlighted the need to better support families who have a child/loved one who is questioning their sexuality/gender. Continuing support is needed for both the family having difficulties in supporting or accepting the person or child, and the person or child themselves. Along with this clinical file analysis, a ‘LGBTIQ communities risk screening and outcome Tool’ was developed as one method to identify the variable risk and protective factors and the nexus between multiple risks and impacts on specific cohorts.

At the time this research was conducted, the number of trans people seeking support was much smaller, however this has increased substantially over the last 4 years due to our own investment and advocacy by our queerspace service. Based on this work, the lived experiences of our clients, and the communities we work with, we know young TGD people with supportive parents and families are far less likely to have suicidal thoughts and seek help if they do. Those without family support are more likely to experience depression, as well as experience abuse at home. This exacerbates risks that result in poorer outcomes across a whole range of social health indices; i.e. employment, education, positive peer and family connections and mental health, which in turn increase self-harm and suicide.

In response, queerspace has developed a number of positive, pro-social, safe, affirming, and importantly non-pathologising group programs for TGD young people and their families. We include support and engagement of parents, siblings or other family members to increase their knowledge and skills to assist their TGD child, including with mental health issues. This is a small, but important program with a long waitlist. Currently there is limited resourcing and funding for any expansion, particularly in Victorian growth corridors and regional locations where there are high support needs.



LGBTIQ+ Intimate Partner and Family Violence

The Victorian Royal Commission into Family Violence recognised the nexus between experiences of family violence and intimate partner violence and mental health, including the lack of, and invisibility of support for the LGBTIQ+ community. In response, the Victorian government invested in a specialist LGBTIQ FV/IPV service ‘w/respect’, of which drummond street/queerspace is the lead agency.

In this service we see significant rates of mental health distress among those also experiencing or using violence. ^(30, 31, 32). This reflects Vic Health’s finding of the wide-ranging and persistent effects on cis women’s physical and mental health ⁽³³⁾ who experience IPV, and research that identifies men who have experienced IPV as more likely to report depressive symptoms compared to men who have not ^(34, 35). Given research shows LGBTIQ+ people experience poor mental health at higher rates than non-LGBTIQ+ people ⁽³⁶⁾, this suggests these correlations continue to need serious responses to address mental health impacts for LGBTIQ+ communities.

Table 7 Risk Factors to Mental Health Distress

	ds clients	w Respect Clients (experience of IPFV)	Queerspace clients at risk of or experiencing homelessness	Queerspace Clients who are Unemployed	
MH Distress	83%	88%	97%	93%	
Demographics					
	ds clients	Queerspace ATSI Clients (n = 7)	Queerspace Clients Born Overseas (n = 65)	Queerspace Clients with Main Language Other than English (n = 18)	Queerspace Clients with a Disability (n = 13)
MH Distress	83%	100%	88%	89%	85%

LGBTIQ+ Homelessness and disadvantage

The cruel symbiosis of mental health and homelessness is well known. This also applies to those highly vulnerable people in LGBTIQ+ communities. There are a lack of supported accommodation and recovery options for those who experience high levels of distress and which addresses their specific complex and multiple needs and identities. This includes people who require the following;

- acute and sub-acute mental health systems (including suicidality and self-harm)
- alcohol and other drug support/recovery systems,
- IPV services
- out of home care/leaving care (child protection)



Adults from LGBTIQ+ communities escaping IPV need supported short-term refuge options that can address disconnection from both family of origin (where appropriate) and LGBTIQ+ communities, and address the impacts of complex traumas (37). We note the rate of self-harm and suicide risk alerts for LGBTIQ+ clients at drummond street/queerspace who were experiencing (or at risk of) homelessness was twice that of LGBTIQ+ clients without a homelessness risk or experience. Almost one quarter (23%) of LGBTIQ+ clients who were experiencing or at risk of homelessness had a risk alert for suicide. 43% of these clients were also experiencing family violence.

Many drummond street/queerspace LGBTIQ+ clients (with an over-representation of TGD clients) experience complex mental health issues but fall outside of the eligibility of the National Disability Insurance Scheme. Instead they present at emergency departments, acute mental health services and/or are often released to homelessness services or back to violent families with scarce recovery support.

Despite emerging initiatives to improve access to housing/homelessness services among LGBTIQ+ cohorts there remains deficient responses to the most at risk LGBTIQ+ clients to homelessness, (with a trajectory of entering AOD/mental health or justice services) due to:

- Compromised ability to simultaneously engage multiple services to meet their complex health and housing needs.
- Comorbidities not being assessed or responded to (e.g. IPV, extreme social isolation)
- Client vulnerability to the behaviour and attitudes of other consumers in mainstream settings (including violence and abuse in bed-based services)
- Insufficient housing options
- Poor experiences of, or poor homelessness sector response to specific needs of sexually or gender diverse populations (38).
- Experiences of past complex trauma resulting in fear of mainstream services (e.g. institutional abuse)

drummond street/queerspace also note young TGD clients who are in or who have recently left the out of home care system, who have histories of family violence and/or complex trauma. These young people can develop considerable needs and risks to both their physical and mental health, which in turn delays or hinders access to other supports such as; gender/sexuality support, sexual health, independent living skills, AOD support and family reconnection/reunification programs.

Policy and Directions for LGBTIQ communities and Considerations for this Royal Commission

Like other marginalised cohorts, intersectional identities and experiences can compound the impacts of adversity. For example; a TGD person of colour, or a lesbian with a disability who contend with discrimination; or a queer person living in poverty who had a disrupted education and is unable to find employment.

drummond street services/queerspace was heartened to see some Government investment directed to LGBTIQ+ communities as part of their *10 Year Mental Health Plan* and the *Victorian Public Health Plan*. However, we would like to see this Royal Commission offer more consistent and embedded change for LGBTIQ+ people across all aspects of the mental health service system, including greater resourcing in prevention and early intervention programs.



We also want respect to the issues of re-traumatisation and risks of harm during the Royal Commission, as experts and services discuss and proffer opinions, pathologies and diagnostic criteria to people's sexuality and/or gender identity. Particularly for older LGBTIQ+ people who may have experienced attempts to 'correct' them in clinical settings. The inclusion of gender dysphoria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and its application and ramification for TGD people should be highlighted. Specifically, the stigma which surrounds non-binary gender identities, despite the growing use of informed consent models of care for transgender people.

Despite our feedback to the Commission prior to its commencement, we do want to reiterate the sensitivities in the context of the convening of public hearings. These are not conducive to elucidate further information from people regarding their submissions, who may not be 'out' about their sexuality and or gender identity. This, in turn may limit key information the Commission should consider. Therefore, drummond street/queerspace believes our role as a key service provider and advocate in providing information on the needs and issues of LGBTIQ+ communities is a vital contribution to this Royal Commission to ensure the needs and vulnerabilities of this community is heard and included.

As we have identified in prior drummond street/queerspace client file analysis there are a range of urgent efforts, which we believe would work to reduce prevalence rates of mental illnesses such as depression and anxiety ⁽³⁹⁾. These views form the basis of some of our recommendations.

In acknowledgement of the specialist needs of specific sub-populations, governments at all levels in policy and service funding should set key targets and outcomes to "close these gaps".

Data collection, evidence on service experience among LGBTIQ+ cohorts needs attention

The LGBTI Health Alliance outlined in their own summaries of international data collection the importance of disaggregated data on different needs among the L, G, B, T, I cohorts ⁽⁴⁰⁾.

We note client/carer experience data on service use, access and experience is not consistent across the Victorian mental health and related systems. The needs and experiences of LGBTIQ+ consumer and carer cohorts are far less understood. Experiences in the mental health system: seclusion, assault, physical/mechanical/chemical restraint, medication, inclusion of their family or key care relationships, support and information for making advanced statements all need to be monitored, in addition to the collection of further complaints analysis data.

Therefore, drummond street/queerspace encourage a strong focus of this Inquiry to identify good practice examples of data collection, along with strategies to better identify the service experiences of LGBTIQ+ consumers, families and carers. This can build an evidence base to improve the help-seeking and differential service system access and outcomes for LGBTIQ+ communities.

It is common for tender and contract requirements with community service providers to include requirements to ensure services have the proper knowledge and competency to engage vulnerable groups. Two cohort examples include First Nations and culturally and linguistically diverse communities. Such requirements could be expanded within policy to include LGBTIQ+ communities. For example, by mandating collection and reporting of minimum service datasets as a measure of aptitude to engage with and provide services to LGBTIQ+ cohorts.



The Royal Commission should also explore the mental health workforce's readiness, knowledge and skills to meet future needs and demands of LGBTIQ+ and other at-risk populations. drummond street services/queerspace can offer expert advice to the Commission and beyond regarding the implementation of workforce initiatives to be led by organisations that:

- are designed and run by LGBTIQ+ communities,
- who already provide mental health support to LGBTIQ+ communities (inclusive of families and carers);
- who are actively using data collection methodologies which collect unique data on all L, G, B, T, I, Q cohorts

Recommendation 10: Government provide investment for research to expand knowledge of the relationship between known risk and protective factors to mental health and the wellbeing of LGBTIQ+ communities (such as a trial of an 'LGBTIQ communities screening and Outcome Tool').

Recommendation 11: Government fund trials of clinical interventions which can address both **common** and **unique** risk and protective factors for mental health of each LGBTIQ+ cohort.

Recommendation 12: Government fund specialist parenting and family support services for LGBTIQ+ communities and expand capacity for existing LGBTIQ+ peer support models within clinical interventions to address increased social isolation.

Trauma experiences need recognition and wrap around responses to support wellbeing

For the five years of the Royal Commission into Institutional Responses to Child Sexual Abuse, drummond street was the largest Victorian provider of Community Based Support Services. We remain a substantive provider of Redress Support Services that assist survivors access the National Redress Scheme, and provide counselling services to survivors who have accepted an offer of redress under the scheme.

Our experiences in the delivery of these services has provided important insights into the experiences, support needs and recovery pathways of adult survivors of child sexual abuse (ASCSA), including those where the abuse was within family and other settings, not just institutional. Many ASCSA clients experience significant complex trauma impacts across physical (co-occurring health issues) and mental health (mental illness, AOD, suicidality) domains. Their choices of support, often have been limited to private mental health, CASA service or accessing acute care. All of those which presume access primarily to centre-based supports have been impacted by service demand issues, or these services are unable to respond to the broader range of issues ASCSA survivors contend with.

The ASCSA survivors we support do present at mental health services regarding symptoms but are not having the source of their trauma addressed. Nor are the surrounding issues related to the life-long experiences and impacts of trauma, and those arising with loved ones and their children being addressed.



Complex trauma histories, including adverse childhood events or abuse, negative family relationships or environments imbue a survivor's life, which in turn makes the ability to navigate 'normal' life transitions or establish positive personal relationships much more challenging. For instance, women who present with mental health issues such as depression, anxiety, insomnia, suicidal ideation and post-traumatic stress disorder, frequently have underlying abuse and violence issues⁽⁴¹⁾. Additional chronic adversities also heavily impair abilities to establish or maintain relationships, pro-social community engagement, participate economically and maintain material resources.

Based on our client data;

- 93% of our ASCSA clients reported histories of diagnosed mental illness and treatment,
- 45% also experienced undiagnosed or untreated mental health symptoms.

Similarly, a sample analysis of our non heterosexual client files identified that sexual abuse within family of origin was related to mental health categorisations. A higher percentage of non heterosexual clients who were sexually abused in the family context reported diagnosis in the "depression only" (41.4% vs. 22.2%), "anxiety only" (31% vs. 11.9%), "both depression and anxiety" (27.6% vs. 7.8%), and "other mental illnesses" (24.1% vs. 6.3%) categories. Clients who had not experienced familial sexual abuse were more likely to not have had a mental illness diagnosis (70%)⁽⁴²⁾. There is emerging evidence regarding the rates and prevalence of sexual assault experiences between the different LGBTIQ cohorts⁽⁴³⁾, but much more research is required.

The Royal Commission into Institutional Child Sexual Abuse made clear findings that current service systems were inadequate to meet survivors' needs and highlighted the pivotal role of practical supports and advocacy for survivors' applying to a Redress Scheme⁽⁴⁴⁾. There is a complexity of trauma experiences among these clients, with secondary impacts of poorer mental health, such as drug and alcohol use, crime recidivism, relationship issues, parenting issues, IPV, employment difficulties and insecure housing.

Therefore, support services need to be flexible and recovery orientated – not limited only to psychological treatments – which on their own are ineffective. Furthermore, understanding of trauma-informed practices and complex trauma across the 'systems' varies. Our own experience with Redress and ASCSA clients is that the use of trauma informed approaches among services they access is limited and inconsistent.

The Redress scheme as it currently designed, offers only counselling tailored to experiences of sexual abuse and to the *types* and *level* of abuse which occurred⁽⁴⁵⁾. This is contrary to the Commission's recommendations⁽⁴⁶⁾ which refer to 'dedicated community support services for victims and survivors' which include advocacy, support *and* treatments.

Supports also need to be responsive to the circumstances of ASCSA's families, including children, young people, adults and older people; each of whom are more likely to be experiencing their own poor mental health⁽⁴⁷⁾. This should incorporate multiple provisions which can respond to a range of often concurrent risks and wellbeing issues⁽⁴⁸⁾. Such as practical assistance with housing, employment, finances (including access to Centrelink), which are additional to therapeutic interventions⁽⁴⁹⁾. Those survivors eligible for some support within the NDIS report the requirement for find self-advocacy



difficult when NDIS providers are not trauma informed. The help-seeking experiences for many ASCSA survivors in trying to manage their own mental health include;

- Inadequate communication between various points of system contact
- Lack of specialised services to provide the sustained and requisite support intensity
- High workforce turnover alongside a lack of organisational and program stability to mental health and related services
- Limitations/inflexibility of available systems (such as psychiatric services, Centrelink and NDIS) to adapt where a client's circumstances or needs changes, often significantly.
- A lack of ASCSA family and carer specific supports, or trauma informed mental health carer supports.

Case Study A

A couple Adam and Rebecca approached drummond street services reporting limited understanding of systems navigation surrounding Redress. They raised issues of significant distress and anxiety interfering with Adam's day-to-day functioning after remembering childhood sexual assault experiences and wanted to explore recompense options, so he could better assist Rebecca and their unborn child.

During the provision of assistance completing a National Redress Scheme Application, the couple's circumstances changed rapidly with the highly emotional experiences of childbirth, and the death of a family member. Rebecca was then diagnosed with 'conversion disorder' due to unresolved trauma and stress, which manifests in unexplained disruptive physical symptoms. In this instance, it was the manifestation of seizures, impacting confidence in Rebecca's could care for their child unsupervised. These changed circumstances faced limited systems capacity to provide ongoing support, for example;

A combination of factors made holistic service provision for this family difficult, but needed including;

- Reluctance of available services to support a high-risk pregnancy (long term IVF in combination with age)
- Limited capacity to of services to provide follow up due to their catchment restrictions
- Difficulty providing continuity of care/transparency between multiple services
- Personality/behavioural traits associated with complex trauma
- Inability to predict prognosis or resolution of Rebecca's condition, resulting in a lack of specialised psychiatric support
- NDIS ineligibility owing to lack of chronicity of Rebecca's or Adam's condition

Group consultations and a lack of clarity around confidential Inquiry hearing processes has created confusion for our clients. We have also found supporting client participation difficult due to the expediency of this process and short timelines. drummond street/queerspace believe this impacts the likelihood some people will provide evidence regarding mental health support they have accessed due to victimisation from crime; or also for that matter due to ill treatment and experiences



of assault within institutions or the mental health system itself.

Recommendation 13: *The Royal Commission explore ways to create new and improved systems, policy, operational and funding arrangements which complement the complex trust needs; and long-term health and wellbeing issues of ASCSA survivors and their families. Any strategies to improve systems, policy, operational and funding should factor staff turnover, and a lack of organisational and program stability as a significant barrier to ASCSA and their families accessing mental health services and supports.*

Recommendation 14: *Government invest in services for family and carers of ASCSA to assist them with psychological, physical and social wellbeing. Services could include counselling, psychosocial education and support groups, assessment, planning, respite options and advocacy to assist carers in identifying their needs and increase their capacity to support and maintain healthy relationships with their loved ones.*

The impact of harms, real and perceived lack of safety in the system

All human rights are foundational and must be a shared achievement of the Victorian community, not a mere aspiration. drummond street/queerspace would welcome public recognition from the Royal Commission of serious and significant harms done to many consumers and families within the system, irrespective of the challenges this may create for government and institutions.

It would be remiss of any examination of the mental health system not to acknowledge issues of safety in clinical mental health settings, including increased complaints to the Mental Health Complaints Commissioner, and sexual assault statistics identified by the Office of the Public Advocate⁽⁵⁰⁾. Positive mental health outcomes cannot be fully achieved through expansion and further resourcing of current systems without strategies to improve safety. We know that women continue to disproportionately experience abuse and risks to their safety. However so do some other cohorts who experience disadvantage and who are at risk of violence. Sadly, many mental health services are the antithesis of healing, caring and recovery environments.

The work of VIMIAC, the Victorian Women's Mental Health Network and others as identified by the Victorian Mental Health Complaints Commissioner, Ms. Lynne Coulson Barr in the *Right to be Safe* report⁽⁵¹⁾ sets out the need for a comprehensive sexual safety strategy which 'plans, coordinates and monitors action to prevent and respond to breaches of sexual safety in Victorian mental health inpatient units'. The *Right to be Safe* report, and studies examining risks of exposure to institutionalised and interpersonal discrimination⁽⁵²⁾ show the need to rectify the ongoing lack of safety in inpatient environments, including for LGBTIQ+ people. The guiding principles of this strategy need to be applied (urgently) across the full spectrum of the mental health services system to ensure true cultural and practice changes occur and victim survivors, their families and carers concerns are listened to.



We support and refer the Royal Commission into Victoria's Mental Health System to key recommendations in the submission to this Inquiry from the Australian Federation of Disability Organisations (AFDO), Disability Resource Centre (DRC), Disability Justice Australia (DJA), Women's Mental Health Network Victoria Inc. (WMHNV) and Women with Disabilities Victoria (WDV). They raise the issue that while most inpatient units today provide some gender separation, this is an interim rather than a permanent solution. This submission notes, a great deal of previous funding has been directed towards the creation of women-only spaces, gendered areas, safety tools (such as swipe wristbands for gendered spaces, and locks on bedroom doors). However, the Women's Mental Health Network Victoria's public consultation and research suggests there are inconsistencies in adherence to these processes and quality improvements for the purpose they were designed.

We highlight too "Recommendation 6" on page 20 of their submission; *"that women-only corridor and facilities are used for their intended purpose in mental health facilities, with support, flexibility and options provided for gender diverse, intersex, non-binary and gender non-conforming people."*

In our submission to the consultation to the Terms of Reference for the Commonwealth's *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* we raised the issue of being able to determine levels of violence, abuse and neglect.

Similarly, when we consider this Royal Commission into Victoria's Mental Health System, we note point 2.4 of its Terms of Reference states the goal of "better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements..." as a means to deliver the "best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages". We include reporting and navigation of service complaints mechanisms as a key part of this goal.

Where evidence is received during the Royal Commission which identifies particular individuals as having been subject to violence, abuse or harm within the system it is important to acknowledge the variable forms of violence, abuse, neglect and harm which are specific to the circumstances of a person having a mental illness. In other words, particular actions may have very different ramifications for, and impacts on a person with a mental illness, and abuse may take forms for a person with a mental illness which are not perceived as abuse. In addition, instances where protection from particular types harm are not adequately mandated by legislation relating to quality and compliance, a failure of duty of care becomes more difficult to prove.

We recommend the Royal Commission into Victoria's Mental Health System explicitly refer to the task of identifying the level to which incidences of violence, abuse, neglect and harm brought before the Royal Commission breach the threshold of human rights, duty of care, quality and compliance and other legislated breaches of Criminal Law; and, that these types of action or inaction are then able to be categorised in a way for future which mandates preventative actions or incur a particular response.

We also note the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Letters Patent includes a definition of *people with disability* which includes "people with any kind of impairment, whether existing at birth or acquired through illness, accident or the ageing process, including cognitive impairment and physical, sensory, intellectual and *psycho-social disability*"



Therefore, it remains possible information and evidence provided to this Royal Commission into Victoria's Mental Health System which lies beyond the scope of the Terms of Reference may subsequently be referred by individuals and organisations to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

We would welcome publicly available information on the arrangements in relation to current and previous inquiries, in Australia and elsewhere. This includes on how evidence and information provided to the Royal Commission into Victoria's Mental Health System will be shared in ways consistent with relevant obligations of these inquiries, so their work including, any necessary consents and the testimony of witnesses, can be considered in ways which prevents unnecessary duplication, improves efficiency and avoids unnecessary trauma to witnesses. We believe indication of greater transparency in these matters will build much needed trust in the process.

Recommendation 15: *The Royal Commission explicitly refer to examination of a means to identify the level to which reported incidences of violence, abuse, neglect by services breach the threshold of human rights, duty of care quality and compliance and other legislated Criminal Law; and, whether reporting mechanisms ensure such determinations can be made.*

Examine coordination of National and State planning and policy approaches

drummond street/queerspace recognise the Government's \$705 million commitment to mental health in the State Budget, and note it exceeds the 12-month expenditures recommended by Mental Health Victoria⁵³. We also acknowledge the Victorian Government's commitments in response to the needs of clients accessing the mental health service system who are not eligible for the NDIS, or who are waiting for their NDIS plan to begin. However, we are aware more investigation is required to rectify long-term systemic gaps due to a decade of funding that was not commensurate to needs. drummond street/queerspace would like to see the Royal Commission examine and explore ways to support planning and investment in mental health with the aim to reduce and avoid duplication, improve integration and seek opportunities to build on existing investments.

We note the State Government and PHN collaborations initiated as part of Victoria's Suicide Prevention Framework 2016 – 2025. We would like to see some analysis of commissioning process in the scope of this Royal Commission. We believe it is timely to examine potential opportunities and existing challenges of collaboration between State and Federal jurisdictions to inform the Victorian Ten-Year Mental Health Plan review which is due during the life of this Royal Commission.

State and Federal accountabilities should be examined to improve continuity of care between Commonwealth funded services available thorough GPs and the state-funded hospital system. This 'missing middle' (⁵⁴) means many Victorians have few options but to present at hospital emergency

Recommendation 16: *The Royal Commission into Victoria's Mental Health System undertake a review and analysis of current collaborative jurisdictional policy and investments to include and ensure a public health response to risk factors of poor mental health is coordinated appropriately.*



departments. The Australian Institute of Health and Welfare note numbers of people presenting at Victorian emergency departments with mental health crises has risen by above 60 per cent over the last ten years and needs to be addressed ⁽⁵⁵⁾. We believe further State ownership of and responsibility for community mental health services should be clarified in the context of a royal commission.

Recovery Oriented Service and Co-Production and Peer workers in mental health

The links between complex trauma and significant mental illness are well known. A plethora of research shows the long-term, broad *negative* health and wellbeing outcomes experienced by trauma survivors throughout their adult lives and within the mental health service system.

There is some evidence of positive outcomes with the management of psychological impacts and symptoms of trauma (psychological and psychiatric treatment), but not a lot of information showing evidence-based programs that demonstrate *long-term* positive outcomes in response to complex trauma, including childhood and adult experiences of abuse and violence (physical and sexual).

As raised earlier many trauma survivor's experiences of the mental health service system can be significantly retraumatising. Recovery-orientated models, that elevate the inclusion and emphasis on the 'lived experience' and peer recovery support is gaining traction, and increasingly extolled for its transformational potential. These models have been slower to be embedded within the Australian context.

Benefits of recovery-oriented mental health service systems include:

- Working effectively alongside psychological treatments and responds to complex impacts of trauma towards recovery
- Improving the ability for mental health services to engage and provide support to marginalised communities, i.e. refugee communities, LGBTIQ, ASCSA
- The development of a more inclusive mental health workforce through the recruitment and training of lived peer workers

drummond streets designed the ***iHeal* Recovery Support Service**, based on these principles, focusing on the longer-term recovery needs of people with significant mental illness and complex trauma.

Our approach with the *iHeal* model ensures peers (from the very communities who too often are overlooked or have experienced poor help-seeking) are trained and supported in roles where their skills and 'lived' knowledge are valued as they work alongside clinical therapeutic support staff. This improves the agency's overall effectiveness in responding to the multiple and often concurrent clinical and case management needs of clients.

We believe this model is a cost-effective mitigation for a range of sectors to address poor engagement of marginalised communities, critical workforce shortages and resource and employment costs.



iHeal Model case study

iHeal is a peer support program using a recovery-oriented support framework. The iHeal model focuses on therapeutic, evidence-based clinical trauma supports, as well as addresses the social, educational, employment, housing and financial impacts (requiring system navigation and casework support) associated with complex trauma.

In addition to our specialist clinical support (adult and child), the *iHeal* program builds a peer-based, recovery casework and support workforce to work along-side clinicians and address a range of secondary impacts of trauma experiences.

Our *iHeal* Recovery Support Worker (peer) model harnesses a workforce through the recruitment and accredited training of people with lived experience, and who also come from the communities of concern, including participants from diverse communities (disabilities, ATSI, LGBTIQ, and culturally and linguistically diverse).

The project to date, has achieved measurable positive outcomes for survivors presenting to us for support (reductions in psychological distress, increased community connections and improved hope or agency). Additional benefits for the *iHeal* Recovery Support Workers include:

- building employment skills to support other trauma survivors;
- access to accredited training, resulting in a qualification that is recognised, valued and critically needed within the sector and;
- supports to their own recovery (and those of their children and families)

The survivors we supported through this approach have been engaged more effectively and sustained over time. This is due to the ability to offer tailored and dual support; by qualified, clinical professionals, as well as from someone who understands their experiences. *iHeal* peer support also serves as an aspirational resilience-building model, giving survivors hope that they too can enter or re-enter the workforce as part of their longer-term recovery.

In our '*Building the evidence base of risk and protective factors for depression and anxiety within the LGBQ Community*' a large proportion (41.8%) of our clients specifically requested to see a queer-identified counsellor, which suggests the availability of queer-specific services is important in enhancing the accessibility of mental health care for LGBTIQ people ⁽⁵⁶⁾.

There are a number of promising initiatives to increase employment opportunities for a range of cohorts in the health and human services systems. We commend the work of the Future Social Services Institute and are participating as a support agency to the *Enhanced Pathways to Family Violence* work project as part of the Victorian Government's 10-year plan for Victoria's future family violence workforce.

The *Access to Mental Health Services* (VAGO) report also notes the completion and release of the DHHS workforce strategy, as well as the Victorian 2018–19 budget funding provisions for additional mental health workers. However, the workforce strategy does not include targets for the types or numbers of



workers it aims to attract or retain, nor set out actions to address the significantly greater staffing challenges that regional and rural areas face. Further, the strategy is not integrated with service or infrastructure planning⁽⁵⁷⁾. We urge the Royal Commission recommend an increase in the implementation of recovery-oriented service models that can build a lived experience workforce across a range of sectors which service people and families who are experiencing the lifelong impacts of trauma.

We want to emphasise the critical import for people from diverse communities to work in support organisations where their specific communities' needs are identified, addressed and captured in data collection and evaluations; and where their communities are represented across multiple levels of the agency.

The work of our *iHeal* Recovery Support Workers clearly and positively augments those of specialist mental health practitioners. It allows us to increase crucial case management and systems navigation, such as social, legal, housing, education, employment and children's services to improve people's help-seeking experiences and overall outcomes. Furthermore, the *iHeal* training and employment model is cost-effective, as workers are remunerated in accordance with their responsibilities. This offers benefits in addressing workforce shortages based on geography or requiring culturally competent workforces and approaches (i.e. LGBTIQ, CALD).

iHeal is also very effective in enhancing community engagement by ensuring services have a more inclusive workforce that reflects the client presenting or needing support. By incorporating transferable qualifications and undertaking holistic case management work pathways for peer workers, this model could be readily be expanded.

We note the third highest principle diagnosis made during mental health-related hospitalisations with specialised psychiatric care are reactions to severe stress and adjustment disorders⁽⁵⁸⁾. We believe similar programs/models of practice to iHeal could be useful for people in recovery from mild to moderate mental health conditions to support them to prepare for and adjust to significant life transitions. This model would also serve well as an early intervention strategy for cohorts at higher risk of poor mental health to reduce the likelihood of an episode or before a life challenge becomes an on-going crisis.

Recommendation 17: *Government invest in recovery-oriented service models and programs that place emphasis on building a lived experience workforce to address the lifelong needs of complex trauma survivors, their families and carers. These models and programs should span a range of sectors which come in regular contact with clients experiencing complex trauma; and engage communities who face barriers to service access and employment such as LGBTIQ+, people with refugee backgrounds and people with a disability.*

Assess, identify and respond to the needs of Families and Carers

The role of families and carers is critical, and they are key in terms of client support and recovery. However too frequently they are not treated as such in clinical settings. Mental health interventions that lack acknowledgement of families or do not include them as part of the therapeutic and recovery



processes can have significant consequences on the effectiveness of treatment and support outcomes for the individual child, young person or adult.

Most individually focused psychosocial interventions do not place a high enough value on family involvement which in turn can isolate or remove someone from the natural, safe or preferred social supports, and increase shame, stigma and fear. Interventions focused only on individuals frequently miss critical opportunities to strengthen supportive and caring relationships by the engagement and involvement of their families. Mental health impacts on everyone within a family, but by limiting focus on individual outcomes prevents wider exploration of these effects (positive or negative) on the whole family of a person accessing services⁽⁵⁹⁾.

From an ethical standpoint, family/carer-centred models must consider family/carer resources, competing demands, and should protect families from unjustifiable responsibility. Issues to consider regarding family/carer involvement in supporting loved ones are; loss of economic participation in other livelihood activities, interference with domestic duties, and secondary stigmatisation. An estimated 56% of carers experience at minimum moderate depression, and one fifth severe depression in addition to high levels of anxiety, psychological distress and lower perceptions of self-worth and personal well-being overall needing their own mental health support. ⁽⁶⁰⁾.

Issues of stigma for carers in mental health settings, negative or dismissive perceptions of their caring role, guilt and shame can hinder their own help-seeking. We refer the Commission to *Tandem's* submission that outlines the many negative experiences of families and carers within clinical systems and a lack of inclusion. ⁽⁶¹⁾. The application of Standards of Practice when working with families of people with a mental illness in the mental health sector has been well articulated ⁽⁶²⁾.

We concur with *Carers Victoria* on the need to create 'an ecosystem of carer identification' and conversely to close 'circles of care to enable better care for carers' and families ⁽⁶³⁾. Mental health consumers may also have their own care responsibilities, including for people with complex or comorbid presentations (such as intellectual/ physical disabilities alongside a mental illness). It would be beneficial that consumers of mental health services and other related supports be routinely screened during assessments and review about their care responsibilities.

Interventions aimed to increase family/carer knowledge and capabilities are noted to be among the most helpful and effective. Such intervention can reduce feelings of 'burden', distress, psychological/emotional support and increase coping/crisis management skills, quality of life and self-esteem ⁽⁶⁴⁾. If these supports are offered early, it helps both carers and their loved one experiencing mental health distress maintain supportive relationships and improves overall family functioning and recovery.

drummond street/queerspace believes mental health system data collection capability needs to reflect the complex circumstances of consumers and apply best whole of family and carer practice models. Standardised, shared data collection tools, which do not only identify carers in relationship to people they support but recognise their own specific mental health support needs as service users, will build better understandings of how to support them.

Improving data and outcomes collection requires leadership from Government departments for carers, including those who are consumers themselves. We refer to Carers Victoria's submission, noting the following two recommendations specifically:



“Improved access to carer needs assessment within mental health services and/or screening to identify and refer carers to appropriate carer support services.

“Improved access to evidence-based early intervention programs for carers starting out in the carer role to mitigate some of the negative mental health impacts of caring.” (65).

We also refer to *tandem’s* recommendation to invest in “*services that support family with the maintenance of their own emotional and physical wellbeing. These include respite, peer support, psychosocial education, assessment, planning and direct service to assist carers in identifying their own support needs, particularly mutual support and self-help services*” (66).

We are aware additional reliance on informal supports will increase for the duration of this Royal Commission as people experience distress and fear related to perceived and actual unsafe experiences in the mental health system. This will subsequently increase the need for support for carers and families. We encourage close consultation with Carer and Consumer peak organisations and service providers supporting participants to monitor the impacts of this process on participants

Recommendation 18: *Government improve access to mental health, related services and family/carer supports as per recommendations by Carers Victoria and Tandem identified in this submission.*

Recommendation 19: *Government provide more information and resources on the Royal Commission processes that target participants, their families and carers; and, release funding for agencies working closely with participants in this Royal Commission so their families/carers have increased capacity to advocate for and/or access emotional supports during the life of the Inquiry.*

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- ⁶⁴ 23 Schumacher, K., Beck, C. A., & Marren, J. M, 2006, *FAMILY CAREGIVERS: caring for older adults, working with their families*. *AJN The American Journal of Nursing*, 106(8), 40-49
- ⁶⁵ Carers Victoria (2019) 'Initial Submission Royal Commission into Victoria's Mental Health System July 2019', Melbourne, p. 5



⁶⁶ Tandem (2019) Royal Commission into Victoria's Mental Health System p. 12