Attachment One: Monash Council Formal Submission to the Royal Commission into Victoria's Mental Health System

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

Monash City Council's suggestions to improve the community's understanding of mental illness and reduce stigma and discrimination include:

Maternal and Child Health

- Increase the community's understanding about the mental health issues that may arise for both mother and father following the birth of a child. For example it is not well understood that Post Natal Depression (PND) can have environmental factors and can also be a chemical imbalance. Education about mental health conditions that may affect new parents and the support required may assist to remove some of the stigma, and assist families/friends to recognise symptoms and support new parents to access timely intervention.

- Increase the discussion around mental illness including depression and anxiety during pregnancy to ensure new parents have a greater awareness of PND prior to the birth. Include in these discussions the signs and symptoms and focus on ways to support and assist new parents i.e. encouraging sleep, cooking meals, assisting with community supports. Greater education on this topic could be incorporated into hospital prenatal education classes.

Workshops

- Make greater funding available for understanding Mental Health workshops in the community (for example Wellways Introduction into Mental Health, Building a future https://www.wellways.org/our-services/building-future-and-building-future-snapshot or Mental Health First Aid training).

Families/Carers education

- Support families and carers to understand mental illness so that they are equipped to manage the challenges of living with someone with a mental illness. The new integrated carer support funding and carer gateways with connection to localised services will support families and is a positive step - https://www.dss.gov.au/disability-and-carers-carers/integrated-carer-support-service-model.

Educational Settings and Young People

- Ensure greater education in schools and other educational facilities about mental illness, mental wellbeing and where to get support.

- While there is funding to target at risk young people, there is need and value in a whole of school approach to mental health community awareness beyond targeting at risk young people.

- Provide stronger acknowledgement of the experience of young people and their mental health concerns. A report produced by Resilient Youth Australia Limited in 2018 from a survey completed by 8,462 Monash young people (Yr 7-12) found that 42% are constantly under strain, 34% are unhappy and depressed and 26% feel worthless.

General Public Information Strategies, including for Culturally and Linguistically Diverse (CALD) communities and carers

- Initiate new public information strategies and campaigns to increase the community's understanding of mental illness, reduce discrimination and to increase knowledge about what to do if you believe someone is unwell. This could include:
    - campaigns on television and social media; media articles; sharing of stories; videos; promotion of key websites; conveying what are the actual clinical diagnoses of depression and anxiety.
    - providing more information about anxiety and loneliness in relation to mental health issues including information around staying socially connected and engaged with your local community.
    - media campaigns with a key message in other languages can be impactful.
- Ensure information regarding mental illness is easy to access, including for culturally and linguistically diverse people through translated, visual, culturally appropriate and potentially interactive material.
- There is a need for training of carers in understanding mental health, particularly in CALD communities, to increase the knowledge of mental illness and reduce cultural barriers to accessing professional support. Lack of knowledge and understanding about general mental health is a bigger issue in many cultures than stigma. Some communities report that 'mental health' is not part of their community's vocabulary. The current approach of a referral to a professional counsellor is not always working as some people are not following up or not able to follow up on these referrals.

Promote data

- Collate and promote research and meaningful statistics, such as prevalence rates of mental illness (overall and subgroups i.e. gender, CALD status, age etc), signs and symptoms, percentage of people who access/do not access support, highlight the benefits of accessing support at key life stages and the possible impacts of not accessing support.

Share best practice with workplaces

- Share best practice workplace e-learning modules broadly available to workplaces that may not have the resources to produce their own modules, with the aim to improve the understanding of mental illness, thus reducing stigma and discrimination.

Increase opportunities for information distribution

- Consider using additional opportunities for information distribution and self-assessment tools, such as when families enrol into early childhood services and school, particularly secondary school.

Public Health

- Treat mental health as a public health issue.

Recommendation

That the Royal Commission considers the need for a comprehensive multilingual community awareness campaign, materials and community education about mental health to increase knowledge, reduce stigma and promote community supports and intervention agencies.

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

What is already working well?

- Training young people, secondary school teachers and the community in Mental Health First Aid.
- Mental health treatment plans (PHN funding) (providing subsidised access to counselling/psychologists) https://www.emphn.org.au/images/uploads/files/PS-Child-Mental-Health-Info-Sheet_Client_0117.pdf
- The Edinburgh postnatal depression screen is completed at the 4 week Key Ages and Stages visit or when required by all Maternal and Child Health Nurses.

What can be done better?

Recognition of the expertise of referring professionals (Maternal and Child Health Nurses) to allow for an easier referral process and increased community supports

- There needs to be greater understanding and respect between services. When a Maternal & Child Health Nurse (MCHN) working with clients who have mental health issues refers to a higher needs service, the service does not always respect the assessments by the nurses or see them as valid. As a result this may delay the uptake of mental health services for these clients.

  For example, the experience of some MCHNs is that parents are often reluctant to report Post Natal Depression. Given the reluctance to self-report, when the parent does manage to disclosure the client may be at breaking point. The nurse screens their status using the Edinburgh Postnatal Depression Screen.

  Despite recording extremely high scores, there are several instances where a GP has dismissed the assessment of the MCHN, and considered the client to be "tired" and the client has left without a referral to an intervention program. These parents then may not seek any further support and be left isolated in the community. This example is not an isolated occurrence.

  The Mental Health System could be strengthened for clients if MCHNs were recognised as able to identify the early signs and have their referral supported. This may result in additional people receiving more timely treatment and support.

- The process could be further streamlined by allowing MCH nurses to refer directly to a psychologist to commence subsidised mental health plan supports. This would reduce the need for clients to explain their situation repeatedly before accessing a service provider. This may mean providing MCH nurses with a more robust, validated screening tool.

- In relation to Maternal and Child Health, encourage the inclusion of partners in treatment plans. Presently a parent experiencing Post Natal Depression may have a treatment plan developed without the partner's knowledge or understanding. The partner is then unaware of how to notice if symptoms are worsening or know when / where to seek help. Post Natal Depression can be a life threatening illness. MCH Nurses are well placed and experienced to provide the parents with extra supports during the treatment phase.

Supporting clients to seek help

- There would also be great value in a service that physically supports the client to seek help. Clients are often not in a state where they can seek help. Assisting clients to seek support

themselves would greatly assist getting people in early support and treatment, for example, facilitating the application for a Mental Health Care Plan, rather than attending a GP clinic. Case Management style support services are needed to help book appointments, arrange transport from home etc. Navigating the system can be overwhelming and beyond the capacity of a number of people with mental illness.

'Keyworker' and Outreach to facilitate uptake of services

- Key access point and coordination – a 'keyworker' to help facilitate appointments.
- Outreach services. The state of a client's mental health can be a barrier to attending appointments. We repeatedly hear from families with young children that they are unable to get to daytime psychologist appointments. Outreach services in a local community setting would encourage timely uptake of support eg supported playgroups
- Follow up/check-in's between appointments/post treatment by the mental health service provider.
- Mental health issues are a common factor for people who are rough sleeping and can be compounded by the length of time spent without appropriate housing increasing the complexity of seeking and maintaining housing when it becomes available.
- Outreach workers who are skilled in engaging with rough sleepers who are experiencing significant mental health concerns, and who may be self-medicating with alcohol and other drugs. Trained outreach workers are required to successfully assist rough sleepers to navigate the supported housing options required.

  The City of Monash currently lacks outreach services including homeless outreach and services such as Bolton Clarke's Melbourne-based Homeless Person Program.

Training & Education

- Make training young people and the community in 'Mental Health First Aid' more widely available and free, including Neighbourhood Houses' staff.
- Reduced fees and fully rebated GP/specialist appointments for vulnerable clients. The gap payment for services is a substantial barrier to many clients.
- Specific training for GP's to be better able to identify poor mental health and competently and confidently refer to psychiatric services.
- More space/facilities for inpatient treatment.
- Access to information in the clients first language and where required, more translated materials and interpretation support.
- Service providers and community leaders report that there is a lack of knowledge of what mental health is in many CALD communities. Clients are facing a lot of stress and additional challenges. Knowledge of what is stress, how stress can affect mental health and response can limited. There can be a scepticism towards the concept of the importance of good mental health and the mental health system.

- Multilingual communication education sessions are vital to improving CALD uptake of mental health services – for example training multilingual workers to attend various groups, clubs and organisations as a free mental health speaker.

Viewing Mental Health in a holistic manner

- View mental health in a holistic manner, such as its relationship with other public health issues including Alcohol & Other Drugs, Gambling, and financial stress, housing stress and family issues.
- Increased funding for programs and services that connect and develop community support and relationships ie neighbourhood house programs.

Clearing waiting lists

- Waiting lists are a barrier to timely uptake of services. A service provision model needs to ensure timely access to treatment.

Recommendation

That the Royal Commission considers the following suggestions:

- *Providing subsidised access to psychologists, identical to the mental health treatment plans, via a direct referral from Maternal and Child Health Nurses.*
- *Developing a service where an outreach worker assists in making appointments, organising transport and providing ongoing flexible, practical assistance to support people to link into supports, and continue supports.*
- *Providing Homelessness Outreach workers who are skilled in engaging with rough sleepers who are experiencing significant mental health concerns.*
- *Establishing a funded service to support the 'Missing Middle' – a service to support young people with higher needs than headspace but not requiring hospital care, eg a headspace Plus.*
- *Funding trained welfare co-ordinators in all schools with professional clinical supervision, to support referral to local services.*
- *Adequately funding youth friendly GPs to provide mental health care plans in accessible locations such as schools and Youth Services.*
- *Increasing communication from the Department of Education and Training about mental health programs available to schools and teacher release, to ensure staff are adequately trained in mental health.*
- *Providing trained multilingual mental health educators as a free resource to speak to groups in the community.*
- *Making training young people and the community in 'Mental Health First Aid' more widely available and free.*
- *Expanding current mental health service provision to remove waiting lists and guarantee timely access to treatment.*

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

What is already working well

- Eastern Region Suicide Response group is working towards containing the impact of suicide.
- Public information about what to do if you thing someone is unwell and "RU OK?" Day.
- Media providing references to Lifeline.

What can be done better to prevent suicide?

There needs to be immediate access to services when needed with increased length of time for services to be involved.

- Clients with acute mental illness often seem to be given inadequate levels of mental health support with many examples of them being sent home from emergency departments a few hours after a significant suicide attempt. This happens without ensuring adequate wrap around services for the adult with mental illness and the children for whom they are responsible.
- There is a need to increase the capacity of the system to allow for both adequate treatment time in service, support after a suicide attempt and also ensure there are services in place for both the adult and their children if there are in their care.
- The current system often appears inadequate to meet the demand for services, compounded with demarcation issues, where the processes to resolve this can be an impediment to timely urgent treatment. The accessibility and response time by highly trained services need to be more readily accessible as a matter of urgency.
- Having to revisit a GP to be reassessed for a mental health plan is disruptive to treatment as many clients take 10 sessions to find the right provider and feel comfortable to begin to unpack their challenges. Better access to a longer mental health care plan such as allowing for the 10 sessions to be rolled over twice without having to revisit a GP would be valuable in many circumstances and would encourage continued treatment when required.
- Better data identifying suicide trends (area, age, school, etc) to plan for targeted activities/programs.
- Greater information sharing with service providers when a suicide has occurred, in order to provide better support other youth.
- Increased training of emergency department staff to recognise and assess risk when community members are brought into the emergency department because of poor mental health but then are released and go on to complete suicide.
- Fund more preventative services and supports.
- Accurate media reporting on suicide and using the correct language – rather than 'accidents'.
- More space/facilities for high risk patients in mental health units are needed to meet demand.
- Holistic treatment options – outreach programs to enable timely, easily accessible support.

- Improved focus on issues around homelessness, social isolation, job availability etc.

Recommendation

That the Royal Commission considers the following suggestions:

- *Improving the accessibility and response time by highly trained services to a mental health crisis as a matter of urgency, through increased resourcing of crisis care and removing demarcation issues.*
- *Increasing the capacity of the system to allow for both adequate treatment time in service after a suicide attempt, support after a suicide attempt and also ensure there are adequate wrap around services in place for both the adult experiencing mental illness and any children for whom they are responsible.*
- *Providing continued access to subsidised mental health support after 10 visits under a mental health treatment plan, without the need to revisit a GP.*
- *Reviewing and providing a better model of care for people with acute mental health issues or who feel suicidal.*
- *Establishing one State-wide psychiatric triage crisis telephone number that will transfer clients, families and carers to the relevant service.*

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

4.1 Better integrated Support Services and better access to local services for our residents

The City of Monash is supported by three separate mental health services for young people and two for adults and two for aged care, as defined by geographically based service areas. The boundaries do not take into account accessibility of the service for Monash residents. The following describes the complexities of the three different geographical service areas to provide an understanding of how better integrated and accessible services would support our residents.

Youth Services

Currently the City of Monash is supported by three separate mental health services for young people aged 0-25, with most of these service centres located outside our region. Figure one Child & Adolescent Mental Health Service Area – Eastern Metropolitan Melbourne (Refer Attachment One, Figure One) shows the local government areas that are funded by the state for Eastern Health.

Eastern Health Supports 75% of Monash's population.

- Eastern Health works in the suburbs of Burwood, Ashwood, Chadstone, Mount Waverley, Glen Waverley, Notting Hill, Mulgrave and Wheelers Hill.

- Young people in these suburbs from 0-25 currently are required to travel to **Box Hill** to access Eastern Health's service. Box Hill is outside the City of Monash and there is no direct transport or road networks that lead to Monash.
- Eastern Health does not have any services located in the City of Monash or along the Glen Waverley rail corridor.
- The YETTI (Youth Engagement and Treatment Initiative) program funded by Federal Eastern Melbourne Primary Health Networks is located at Monash Youth Services 1 day per week.
- If a young person attends Monash Medical Centre with an emergency, they will receive initial treatment but will be referred to Eastern Health in Box Hill if there is a place available.

Alfred Health and Monash Health share 25% of the City of Monash Mental Health Service Area (Refer Attachment One, Figures Two and Three). Alfred Health will support young people from 0-17 and Monash Health will support young people from 18-25.

- Alfred and Monash Health cover the areas of Hughesdale, Oakleigh, Huntingdale and Clayton.
- Young people 0-17 access Alfred Health services in **Moorabbin**, outside of Monash.
- As Alfred Health does not have emergency services in Monash, Monash Health manage all emergency cases and refer back to Alfred when suitable.

Monash Health have the Monash Children's Hospital and Early in Life Mental Health Services (ELMHS) located in the City of Monash.

- **Young people 0-17 living in Monash cannot access these services** even though they are actually located in the City of Monash. The Hospital's Mental Health catchment is for the Greater Dandenong, Casey Cardinia and Peninsula Regions. Young people can only access these services if they require emergency supports but then they will be referred to their local area service.
- Young people aged 18-25 can access Monash ELMHS in Clayton.
- 18-25 year old young people access Monash Health in **Dandenong.**
- Inpatient services are offered at Monash Medical Centre through Stepping Stones. This is a joint venture between Monash and Alfred Health Services.

Adult Services

Monash is divided into two services providers for adult Mental Health Services: Monash Health (Middle South – refer Attachment One, Figure Four) and Eastern Health (Central East, refer Attachment One, Figure Five) and Aged Care.

Eastern Health Operate their **Waverley Community Mental Health Service** from Box Hill due to its closure of its local Monash site following an incident. in 2014. Eastern Health reopened the clinic one day per week in Link Health and Community's office in Glen Waverley.
https://www.heraldsun.com.au/leader/east/waverley-community-mental-health-service-remains-closed-nine-months-after-shots-fired-into-building/news-story/128b98022a1c2b9757250509a7e604bf

Aged Care

The City of Monash are also supported by two Aged Care Service Areas, Central and Outer East (Refer Attachment One, Figure Six) and Middle South (Refer Attachment One, Figure Seven).

State Services

Over the last 10 years there has been a shift in service provision to support mental health in the community. Psychiatric Disability Rehabilitation and Support Services (PDRSS**)** were focused on a range of supports for those 18-65. These included:

- Planned respite
- Non-residential
- PDRSS Residential
- PDRSS Rehab. day program
- Home-based outreach
- Self-help and respite.

PDRSS services ceased in August 2014.

In August 2014 a new Mental Health Community Support Service (MHCSS) commenced however it does not offer Rehabilitation day programs. Some clients in Monash needed to transition to new providers. As a result the following changes were made to Services in Monash:

- Mental Illness Fellowship (now Wellways) lost funding to support clients in the area. Funding was however maintained to support families and Carers.
- MIND lost funding to support Monash Clients.
- EACH became the new intake for the region based in Ringwood
- Prahran Mission commenced a service in Mount Waverley
- Neami National continued to provide services in the area but based in Blackburn as they closed their Glen Waverley office.

With such significant changes to the delivery agencies, it took time to build their client lists, with many clients struggling with the transition to the new services without the day programs.

With the introduction of NDIS there was another change to these programs, with NDIS taking over the management of the MHCSS clients.

Monash Children's Hospital School

The Monash Children's Hospital School is a North East Victorian School supporting the transition of students back into education when having a hospital stay. The school can support students in the City of Monash who have a health issue, however in relation to mental health they can only support students who access their Early in Life Mental Health Services. As this service is for 18-25 from the City of Monash (0-17 year olds Monash residents are not in the designated service area) it effectively means mental health patients from Monash cannot access the school and they will be referred to Box Hill. The school based **in Monash** in the Eastern Region, supports young people with mental health issues from the Southern Region, but **not** Monash residents.

Federal Funding

Inner East Medicare local managed the federally funded programs within the City of Monash, covering the whole municipality. When the transition occurred to the larger Primary Health

Network (PHN) Regions in June 2016 the City of Monash was split into 2 regions (Refer Attachment One, Figures Eight and Nine).

South Eastern Melbourne Primary Health Network manage the care plans of clients in Monash's suburb of Hughesdale. The Eastern Melbourne Primary Health Network now manages all other clients care needs. With the introduction of Stepped Care the access point for this service is Access Health in Hawthorn, or for Hughesdale residents the Access point is via South Eastern Primary Health Network.

The description above of mental health service provision in relation to the City of Monash describes the complexities of how Monash residents are assigned to service networks without regard for proximity of service or transport routes. The system needs to be changed from prioritising health networks to providing services to people in their local area, regardless of boundaries or point of contact.

4.2 Other Barriers

Apart from disjointed service provision, other barriers include: long waiting lists; costs; the need for clients to repeat their story several times as part of the referral process; individualistic approach (carer/individual is required to organise; follow up and attend appointments when in many cases the individual needs support for this to happen); fees; English as a second language; lack of understanding by both the client and families about mental illness; and lack of support/supervision between appointments and after treatment, social isolation, wait times to access professional support and settings which may not support good mental health, as described below:

Families

- Families challenged by mental health issues are frequently referred to Family Services. There are a number of barriers for them in accessing mental health assessments, treatment and support. These barriers include delays and waiting lists to getting a mental health assessment through the public system and the costs associated with accessing the private system exclude most of these families.

  When there are concerns for the mental health of children, the situation is even more problematic. The eligibility criteria for Child Youth Mental Health Service (CYMHS) is difficult to understand and at times seems variable. There are then often quite long waiting lists for therapy. This often leaves families very anxious and left uncertain as to how to manage their child's behaviour. The capacity of service provision needs to be increased.

Cost

- The cost of accessing services, including the gap fee under mental health plans, is a barrier. Mental health plans cover a proportion of cost for a number of sessions per year. Not everyone can afford the gap payment and often need ongoing support (for either themselves and/or their child). The out of pocket costs often prove unmanageable and they frequently withdraw from the service. All ongoing mental health services should be bulkbilled for our most vulnerable clients and affordable to low income earners of families not entitled to a healthcare card who cannot afford to pay the gap for services or access private mental health services.

Maternal and Child Health

- As previously mentioned under Question 2, there needs to be greater understanding and respect between services. Currently there is gap where a professional who works with clients who have

mental health issues refers to a higher needs services and that professional opinion is not always respected or seen as valid (for example screening by our Maternal and Child Health Nurses). The result of this is up take of mental health services for these clients takes longer with all the implications of that. Recognising that Maternal and Child Health nurses are very good at identifying when treatment and support is required would help get more people into early treatment and support.

- The repeated need for clients to explain their situation to numerous professionals is built into the referral process makes accessing services more difficult. Maternal and Child Health Nurses could be given a robust and validated screening tool and be able to refer directly to a psychologist or Post Natal depression service.

Mental Health Plans

- As mentioned under Question 3, advocating for the 10 Mental Health Plan subsidised sessions to be rolled over twice more without having to revisit a GP would be of great benefit to clients. Many clients take 10 sessions to find the right provider and feel comfortable to begin to unpack their challenges. Having to revisit a GP to be reassessed is disruptive to treatment.

Service Gap for families without an official diagnosis

- There is a gap in the system relating to young children with highly challenging behaviour and no official diagnosis, who are not eligible for the National Disability Insurance Scheme (NDIS) or Kindergarten Inclusion Support. If the family cannot afford to access psychological services, then the child, families and educators are potentially faced with a lack of mental health support. When this occurs, the child, family and educators can all be in distress. There needs to be expert bulk billed mental health support and outreach for that professional to observe the behaviour in the setting.

Older people

- Sometimes Council receives a referral from Victoria Police regarding concerns that an older person (65+) that seems confused. Council offers Home Support Services and will make referrals to a GP and other services. However clients that may have a mental illness are in our experience also unlikely to consent to services. It is difficult to follow up with a GP about a client with no formal diagnosis and who is resistant to home support services. If there were a pathway with the GP Health Network that allows greater communication with Council Intake Assessment Officers and if Home Support was encouraged to be included as part of the Mental Health Plan, it would be more likely that the client would consent to in home support services and Allied Health support.

- There is no specific funding for people who fall through the gaps. Speaking specifically about the 65+ age cohort, we suspect there are more people with mental illnesses who not accepting services or falling through gaps. Ideally, there would be outreach workers funded to build relationships with older people who are reluctant to attend a referral service, and the outreach workers would be funded to maintain the relationship to facilitate the uptake of mental health and other services, as many individuals are reluctant to move onto another service they do not have a relationship with.

Understanding and support

- Misunderstanding of mental health and lack of family, friend and community support makes it hard for people to access services. This may be from dismissing the seriousness or presence of mental illness due to lack of understanding of mental health, the service system, supports

available, what is required to navigate the system, including practical support of getting to appointments. Additionally there is still a perceived stigma of mental illness in some families, which can be more prevalent in some CALD communities.

Welfare coordination in schools

- Not all schools have trained Welfare Coordination and a dedicated Welfare Support Officer and funding for this in schools would support better mental health outcomes.

Supporting frontline responders to respond

- More support and education for frontline emergency responders such as the police and SES would assist emergency workers in responding to people with an unmanaged mental illness.

Knowledge about NDIS

- There is not a widespread knowledge that respite and the needs of families can be considered under NDIS plans and often we hear that families are told that respite is not eligible at intake, or that respite under a plan is not always approved. Respite is vital for the families' mental health and well being. Allocating funds for carer's mental health in individual plans due to the increased demands on the carers in managing the NDIS plans would also be highly beneficial.

Flexibility

- Complimentary or alternative therapies are not recognised in mental health plans. Feedback from the CALD community and people with disabilities highlighted that when there is a communication issue it can be challenging to seek non-traditional therapies. The gap funding families need to pay to access a psychologist can be more than the cost of a specific complementary or alternative therapy that does meet their needs. For example, an individual with communication difficulties may gain greater mental health benefits from a service such as acupuncture, hydrotherapy or massage rather than talking to a psychologist.

- The community would also benefit from: Mental Health teams located in community hubs to make services more accessible in local community settings (many parents with young children in particular find it challenging to travel to services); more practitioner involvement in organising appointments and follow up; reduced/full rebated fees for most vulnerable clients; holistic care approach – support for family unit and increased access to translation of all written material would all support good mental health.

- PHaMS (Personal Helper and Mentor Service) was a highly regarded federally funded program that has just lost funding in the East. It provided practical support and flexible help without the need a formal diagnosis, and was particularly helpful for migrants who may be less likely to seek a formal diagnosis. It was successful as it was quite fluid and helped people that fell through the cracks. It is suggested that something similar would be of great benefit.

Increase uptake of services from the CALD communities

- Flexible responses to the CALD communities are required. Many cultures don't generally express mental health issues. Trust and language barriers are also common. Settings matter, such as having a professional do house visits or someone who visits go with the client to see a professional. Professional settings maybe too formal for many CALD clients for them to feel safe and to disclose their issues. The idea of going to a professional can be an alien idea and many people in the CALD community, particularly older people, do not understand. There

needs to be dialogue with culturally appropriate services and bilingual workers are vital to improving CALD uptake of mental health services.

Social Isolation

- Social isolation and disconnection from the community can be a barrier for people to experience good mental health. Ways to address this include providing funding to allow for the expansion of programs that encourage isolated residents to reconnect with the community and combat social isolation.

Raising awareness

- Continue to raise awareness of mental health and the services that are available would assist people where lack of knowledge is a barrier to accessing services (migrants, adult men, people who have never been in contact with the mental health system and whose networks may not have provided them with knowledge the mental health system).

Waiting lists

- Long waiting times to access professional care is a barrier to good mental health, for both the client and people who are supporting the client. Fund mental health services to clear long waitlists in community and acute settings. Ensure access to timely, appropriate support as a priority.

Continuity of care

- Improve continuity of care for consumers who age out of a service so there is access to continued support and transition between service types. Implement ongoing dialogue with service users and their families/carers to influence service delivery and provide proactive, agile responses to any emerging service issues.

  As highlighted above this is a complex issue with a number of key challenges and barriers that make it harder for people to find, access and experience mental health treatment and support. The recommendations above are based on extensive internal and external consultation and professional experience.

Recommendation

That the Royal Commission considers the following suggestions:

- *Changing the systems from prioritising health networks to providing services to people in their local area, regardless of boundaries or point of contact through*
    - *Ensuring that the mental health sector is responsive to the needs of clients with a 'No Wrong Door' approach.*
    - *Aligning Federal and State mental health service boundaries.*
    - *Reviewing mental health service boundaries so that Monash residents can access local services as a priority.*
    - *Reviewing health networks so that clients can stay in one service for whole of life care.*

- *Establishing a support for young people transitioning from child and youth programs to adult services.*

- *Making the Monash Children's Hospital School accessible to Monash residents with mental health concerns.*
- *Providing funded Welfare Coordinators in schools.*
- *Expanding mental health service provision to remove long waiting lists, including for CYMHS.*
- *Providing and funding a free mental health support and outreach services for professional experts to observe the behaviour in the setting (for example a kindergarten) where there is young children with highly challenging behaviour and no official diagnosis and ineligible to access other funded programs.*
- *Providing free ongoing mental health services for the most vulnerable clients and affordable mental health services to low income earners (including the carers of children in need of services) who are not entitled to a healthcare card who cannot afford to pay the gap for services or access private mental health services.*
- *Funding a service similar to the PHaMS service for people without a formal diagnosis.*
- *Increasing the capacity of the service provision of Child Youth Mental Health Service.*
- *Providing Maternal and Child Health Nurses a robust and validated assessment tool and be able to refer directly to a psychologist or Post Natal depression service under a subsidised mental health treatment plan.*
- *Funding or advocating for funding to allow Mental Health Treatment Plan sessions to be rolled over without the need for a GP reassessment.*
- *Supporting the establishment of a pathway that allows greater communication between Council intake workers and the GP Health Network and also encourages including Home Support as part of a Mental Health Treatment Plan.*
- *Funding outreach workers, specifically for older adults, to establish an ongoing relationship to facilitate the uptake of mental health services, to be maintained after referral to a mental health service.*
- *Recruiting more bilingual workers.*
- *Increasing the focus and public dialogue around on the settings and structures in people's lives that supports good mental health.*
- *Expanding funding opportunities for programs that encourage isolated residents to connect with the community and reduces social isolation.*
- *Funding mental health services to clear long waitlists in community and acute settings and ensure ongoing access to timely, appropriate support as a priority.*
- *Supporting carers to understand that respite and the needs of families can be considered under NDIS plans and advocate for approval of respite under the NDIS.*
- *Making mental health services more physically accessible, including for families with young children, by locating mental health workers in community hubs.*

- *Increasing support and education for frontline emergency responders such as the police and SES would assist emergency workers in responding to people with an unmanaged mental illness.*

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

The drivers behind some communities in Victoria experiencing poorer mental health outcomes include:

- The service system difficult to navigate.
- There is no consistency of providers across the lifespan. There are different Child/Youth to Adult and Geriatric services. Providing consistency of providers across the lifespan would benefit clients moving between service age cohorts.
- Early interventions services not easily accessible.
- There is a lack of mental health services in certain areas. For example residents in Monash compete with out of area clients to access mental health supports from our local Community Health Services, which does not place a geographical boundary on service provision nor do they prioritise Monash residents. Monash residents are unable to access Community Health Service mental health services in other regions as those other services limit their client list to their geographical area. This means that Monash residents are at a disadvantage, with more people competing for services in Monash.
- Headspace is a service of the Federal Government designed to support young people from 12 to 25 years as an early intervention service. The state government provides support to young people in immediate crisis through emergency departments and Clinical Mental Health Services. These services are provided to young people who are at immediate harm to themselves and others. There is a gap in services to support young people who have mid-range mental health issues. Headspace often holds young people in their care in this mid-range however there is still a significant gap in this service provision. Support Orygen in the headspace plus initiative, https://www.orygen.org.au/About/News-And-Events/2019/Orygen-welcomes-ALP-commitment-to-mental-health-se
- Social isolation and lack of support networks for: new immigrants, single parents/sole carers/new parents/elderly/those experiencing family violence, disability.
- Inexperienced clinicians.
- Lack of specialised mental health services.
- Cultural and language barriers.
- Low socio-economic status, cost of living, unemployment. The mental health plans cover a proportion of cost for a number of sessions per year. No everyone can afford the gap payment and often need ongoing support.
- Homelessness or risk of homelessness.
- Becoming a parent.

- Gender. According to the World Health Organisation (2014) "Social determinants of Mental Health" https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf gender is an overlaying social determinant of mental health and mental illness. Gender differences occur particularly in the rates of common mental disorders – eg depression and anxiety. Gender can affect mental health as gender influences the socioeconomic determinants of the mental health, treatment in society and susceptibility to poor mental health. The vast majority of people who are experiencing intimate partner violence are female, while men in the middle age group are overrepresented in suicide statistics.

- People who have experienced family or intimate partner violence or abuse are at a significantly higher risk of experiencing a range of mental health conditions including post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse, and thoughts of suicide. Family violence is the single biggest cause of homelessness in Victoria with more one third of women accessing homelessness services due to fleeing family violence. Homelessness (primary, secondary or tertiary) expose people to a wide range of risk factors and stressors that exacerbate mental health conditions, while safe, appropriate and secure accommodation are protective factors.

- Anecdotally, Council hears that many men are severely depressed, particularly in CALD communities. Poor mental health in men is reflected in higher suicide rates for adult males. Severe depression can be seen with men who may be victims/witnesses of war, who may be struggling to build new lives in a new culture. This may be compounded by gambling, family violence and/or family break down.

- There is significant cultural challenges, stress and financial strain on international student. International students need health insurance but still need an up-front emergency department fee, which can be claimed, but many people will question whether they will get it back and are reluctant to go to hospital even when there is a significant mental health crisis.

- Many newly arrived migrants come to Australia and have no job, their qualifications are not recognised and there may be language barriers. There are also cultural differences in how children are educated in Australia, there can be generational challenges and some parents not understanding on how to communicate with their children, especially if they don't speak English very well.

- Mental health & older adults – research shows that poly pharmacy use is high in older adults. There appears to be a reliance on medicating older people for mental health issues. Often older adults do not know there are non-medical options.

- Comprehensive research by The University of Melbourne, published in the Australian Journal of Psychology, that looked at 5000 children and linked results to Medicare data, found that:

  > "The vast majority of Australian children with mental health disorders aren't getting professional help, and girls, younger children and families from non-English-speaking backgrounds are the least likely to be accessing services."

  Source: accessed 24 June 2019 fromhttps://pursuit.unimelb.edu.au/articles/australian-children-with-mental-disorders-aren-t-getting-help

  In particular, the study found:
  - Only 30% of those accessing support were girls, even though girls made up half of those identified as needing help.

- Only 2% of children from families from non-English speaking backgrounds accessed help, even though they made up 14 per cent of children needing help for emotional problems.
- The youngest age group in the study were aged 8 to 9 years, with 85 to 90 per cent not receiving help.
- Only 5.1% of children under the age of 15 used Medicare rebated mental health services, yet half of all adult mental health disorders start before 14 years of age. The study also sited previous research where "14 per cent of four to 17 year olds or 580,000 Australian children and adolescents meet diagnostic criteria for at least one mental health disorder over 12 months".
- Children from families of low socioeconomic status or single parents (with little or no increase in service use).

What needs to be done to address this

Mental Health focus in homelessness interventions

- A mental health focus needs to underpin all homelessness interventions from assertive outreach (outreach workers specialising in mental health), to crisis and transitional housing (placement and accommodation dependent on mental health needs), to ongoing case management (workers specialising in mental health). This is essential to respond to the growing number of people at risk of homelessness, who are then rough sleeping.

Mental Health Nurse as part of MCHS

- A Mental Health Nurse, as part of the MCHS, would have a huge ability to both **prevent** and **improve response times** to mental illness, support people to get earlier treatment and support, prevent suicide and support parents in times of crisis.

Service provision to meet the need

- Ensure that the provision of mental health services, specialised mental health services and experienced clinicians meets the need.

Affordable, accessible care for all

- Ensure the cost of ongoing mental health services is accessible to lower income earners.

Schools

- Schools need better access to Safe Minds and other professional development for school staff.

Accessible information about mental health and mental health services

- Provide easy to navigate (and updated) online information/direction in accessible formats. Migrants, including from English speaking countries, often do not know how to go about seeking mental health support. There needs to be an easy guide to seeking mental health support/services.

Addressing social isolation

- Provide for supports such as free local networks and groups facilitated by social workers in partnership with the community in naturalistic settings. For example, local kindergartens have expressed concern about CALD parents and grandparents who appear to be isolated.

Alternative therapies

- Include alternative therapies as part of support.

Greater attention to gender specific determinants

- Give greater attention to the gender specific determinants that promote and protect mental health or detrimentally affect mental health to populations such as women/people affected by family or intimate partner violence, and targeted approaches for encouraging adult men to seek mental health care/suicide prevention.

Housing

- Greater access to affordable housing with security of tenure is essential for people (and their families if they are parents) experiencing family violence.
- Lack of supported accommodation means that younger adults experiencing mental health concerns can end up in aged care facilities when this is inappropriate. There is a need more supported housing options for adults experiencing mental health conditions and crises.

Culturally specific responses

- Interpreters need to understand the context of mental health when interpreting. Similar to the NDIS training that was free for interpreters, to help explain terminology in a language people understand rather than bureaucratic language, would be ideal in a mental health terminology context.
- Provide funding for bilingual community educators to attend community groups and organisations, and for Neighbourhood Houses and other organisations to run ethno-specific information session about mental health. A local Neighbourhood House told us that they recently ran an information session with a Chinese psychiatrist and 40 people attended.
- Training and employing more multi-lingual mental health workers and indigenous workers in mental health services, and/or funding more organisations to have indigenous and multi-lingual mental health workers.

Targeting older adults before entering residential care

- Prevention measures are important, especially in older adults, such as a focus on community care before people enter residential care.

Children

- More research into why particular cohorts of children are not accessing support is required.

Recommendation

That the Royal Commission considers the following suggestions:

- *Providing a Mental Health Nurse as part of every Maternal and Child Health Service, funded by State Government.*
- *Ensuring a mental health focus underpinning all homelessness interventions from assertive outreach, by funding outreach workers specialising in mental health, to crisis and transitional housing, by ensuring placement and accommodation is dependent on mental health needs, to ongoing case management, by funding workers specialising in mental health.*
- *Providing more supported housing options for adults experiencing mental health conditions and crises.*
- *Providing supports such as free facilitated local networks and groups for CALD parents and grandparents.*

- *Creating an easy* guide to seeking mental health support/services, in a variety of accessible formats, reflecting the communication needs of the community.
- *Focusing on community care for older adults prior to entering residential care.*
- *Training and employing more multi-lingual mental health workers and indigenous workers in mental health services, and/or funds more organisations to have indigenous and multi-lingual mental health workers.*
- *Providing funding for bilingual community educators to attend community groups and organisations, and for Neighbourhood Houses and other organisations to run ethno-specific information session about mental health.*
- *Ensuring greater access to affordable housing with security of tenure for people/families experiencing family violence.*

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

Families and carers need financial, emotional, mental and social support, and in some cases, education to help better understand mental illness and how to help. Suggestions include:

Encourage including families in mental health plans

- By encouraging the client to include families in the client's mental health plan, key family members could be aware of the supports in place, or what to look for and what to do or who to contact if the condition worsens.

Increased education

- Increased education about the mental health illness so that families are able to better understand what is mental illness and how to get support. Our staff see clients where the family does not comprehend the severity of an illness and dismisses it, preventing them from helping or encouraging the individual experiencing a mental illness. The denial can lead to delays in obtaining support.

Increased Supports

- Ensure there are wrap around services in place for the client and the children that they are responsible for.
- Greater funding and promotion of Families where a Parent has a Mental Illness (FaPMI) Services.
- Provide a key contact number for families/carers to find out more information about the mental health system.
- Carers of people with mental health need increased support for themselves, such as opportunities to self-care, including seeking support for their own health both physically and emotionally.
- There is a need for more supported accommodation options for adults after hospital discharge. Families are left to look after the client and can struggle with providing support. An example we have been given of an employee sleeping at work as they were unable to cope with the adult child's problematic behaviour after discharge from hospital.
- Many people are telling us that the CAT assessment is extremely narrow and there is a need for help for people in crisis who are just below the level for CAT intervention. Especially as many people, particularly migrants and also Indigenous Australian, may have a negative experience with, or perception of, police and will not call the police in potentially harmful situations.

Expanding the CAT service provision and criteria would greatly support families and carers of people experience a mental health crisis.

Respecting the insights of families

- Respect families' and carers' individual insights into the clients experiencing mental health issues.
- Provide greater education to families and carers to raise awareness that they can provide information to doctors even though the communication can only be one-way.

When people don't fit a category

- There is a need for umbrella support for families of children without a formal diagnosis or children with a delay, including service coordination, planning for families, subsidised mental health care and sibling care (where families are not linked to the NDIS).
- Provide funding/support for carers regardless of whether the individual that they care for is on the NDIS. A family's ability to access the NDIS or not can often affect what support as a carer they receive. Since the introduction of the NDIS, some services are now funded for support for carers who are on a plan and some are funded support for carers who are not on a plan. Ideally carer support programs should allow all carers can participate in regardless of NDIS status of the person they care for.
- Greater knowledge that it is appropriate to provide respite care and consider other family members in relation to the NDIS plans and greater approval of respite under NDIS plans.

Access to services

- Prompt access to mental health services for the client would assist greatly in supporting the wellbeing of the client's family and/or carer.

Recommendation

That the Royal Commission considers the following suggestions:

- *Providing more supported accommodation options for adults leaving hospital.*
- *Ensuring there are wrap around services in place for the client and any children that they are responsible for.*
- *Providing greater funding and promotion of Families where a Parent has a Mental Illness (FaPMI) Services.*
- *Increasing education about mental illness so that families are able to understand mental illness and how to get support.*
- *Increasing the promotion of support for carers.*
- *Providing more supported accommodation options for adults after hospital discharge.*
- *Expanding the CAT service provision and criteria, and the community's understanding of how to use the service.*
- *Providing subsidised support for families with children without a formal diagnosis or children with a delay, including service coordination and planning for family and sibling care where families are not linked to the NDIS.*

- *Providing funding/support for carers regardless of whether the individual that they care for is on the NDIS.*

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

Support could include:

- Reasonable case loads ie lower staff to client ratios in in-patient services, balance of client facing and administrative hours. Caseloads that reflect the needs of the clients rather that the needs of the funding body.
- Supported time for their own mental and physical wellbeing including access to counselling services and mentors on a regular basis and increased clinical supervision.
- Increased pay that reflects the intensity of work that is required particular to front line workers and those managing acute situations.
- Increased professional development opportunities.
- Flexibility in the approach to mental health allowing for mental health workers to tailor services to the needs of clients.
- Better job security, ongoing contracts for services. Some programs are only funded annually. Shorter term funding rounds can impact on an organisation's ability to retain specialised and long term staff, which impacts on service delivery and relationship building.

Recommendation

That the Royal Commission considers the creating initiatives to attract and retain workers, including:

- *Expanding the workforce to meet the demand for services*
- *Ensuring reasonable case loads and remuneration*
- *Supporting workers' mental and physical well being*
- *Increasing professional development.*

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Funding

- Increased and more comprehensive Government funding and facilitation for economic participation for people living with or recovering from mental illness.

Provide incentives and education for businesses to employ and support people with mental health issues

- Increased understanding by work places around mental health with incentives to employ people who have been out of the workforce due to illness, and education to respond to employees compassionately.

- There is minimal support for males who either themselves or their partners are suffering from Post Natal Depression and who might need a gradual return to work in order to support themselves or their partners. There is an opportunity to make this issue known and people to be better supported by their place of employment.

Employment services

- Improved monitoring of employment services funded to support people with mental health issues to be work ready and find meaningful positions.

Train People with Lived Experience as Public Educators

- Provide opportunities for people with a Lived Experience of mental illness to be trained as public educators.

Addressing social isolation

- Fund the provision of local networks and social groups facilitated by social workers in partnership with the community in local settings.
- More funding and support for outreach services to support isolated residents to participate in community life.
- Neighbourhood Houses often see people experiencing mental illness (including from CALD communities). Neighbourhood Houses have programming that connects people and lessens isolation, and could be funded for more to reduce social isolation and help people experiencing stress or recovering from mental illness. Many Neighbourhood Houses follow up and email students that haven't come in and provide a connection and community.

Affordable Housing

- Supporting people with more appropriate, affordable and accessible housing with security of tenure. It is difficult for someone to address mental health concerns without security of affordable and appropriate housing. Security of tenure also means people can establish links into the local community.

Recommendation

That the Royal Commission considers the following suggestions:

- *Ensuring people living with mental illness have access to appropriate, affordable and accessible housing with security of tenure.*
- *Increasing understanding by work places around mental health with incentives to employ people who have been out of the workforce due to illness, and education to respond to employees compassionately and better support people returning to work when either themselves or their partners are experiencing mental illness.*
- *Funding the provision of local networks and social groups facilitated by social workers in partnership with the community in naturalistic local settings.*
- *Increasing funding and support for outreach services to support isolated residents to participate in community life.*

- *Funding agencies to reduce social isolation for people experiencing or recovering from a mental illness.*
- *Providing opportunities for people with a Lived Experience of mental illness to be trained as public educators.*
- *Increasing monitoring of employment services funded to support people with mental health issues to be work ready and find positions.*

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

- Changing the system from prioritising health networks to providing services to people in their local area, regardless of boundaries or point of contact.
- Affordable ongoing mental health services and support. Fully rebated sessions with psychologist/psychiatrist for the most vulnerable clients eg those with low incomes and/or health care cards. Increase access to mental health services as bulk billed services.
- Mental Health Nurses attached to every Maternal and Child Health Service.
- A mental health focus underpinning all homelessness interventions from assertive outreach (outreach workers specialising in mental health), to crisis and transitional housing (placement and accommodation dependent on mental health needs), to ongoing case management (workers specialising in mental health).
- Reviewing the boundaries for services in acute setting. Ideally in acute circumstance where suicidal ideation is present the closet response team should be available and practitioners in community settings should be able to make this call.
- Increased respect between the communities based services and the rapid/acute response teams. Frequently the Enhanced Maternal and Child Health teams are faced with questions on authority and skill to identify increasing concerns around mental health states. This lack of respect and understanding between the mental health teams reduces collaboration and increases the frustration for both services.
- Easier access for people into mental health services for who are suicidal, in addition or as an alternative to attending the hospital or calling emergency services in crisis. Ensure the ability to receive immediate 24 hour mental health support at a place that works for the individual, such as at home, rather than call emergency services.
- More choice for isolated clients, especially outreach support at home or in the community where it is most needed.
- Review the current guidelines around referral to community based practitioners.
- Review the current requirement for referral to GPs for mental health plan and advocate for clients to be able to access mental health plan directly from the service providers after referral from another agency i.e. Five mental health bulk billed sessions with a psychologists then may need see GP for a further sessions through a mental health plan.

Recommendation

That the Royal Commission prioritises the following areas for change:

- *Reviewing health networks to:*
    - *Provide services to people in their local area, regardless of boundaries or point of contact.*
    - *Align boundaries between Federal and State mental health service boundaries.*
    - *Ensure continuity of care for people ageing out of a service.*
- *Providing Mental Health Nurses as part of Maternal and Child Health Services.*
- *Ensuring mental health underpins all homelessness interventions.*
- *Reducing waiting lists.*
- *Funding support for people who presently fall through the gaps, such as children with problematic behaviour without a formal diagnosis who are ineligible for other funding.*
- *Making access into mental health services easier for people who are suicidal.*
- *Creating a range of flexible outreach worker positions, including workers who can support people to access services.*
- *Increasing community education, including providing free Mental Health First Aid, and targeting different parts of the community in different settings.*
- *Increasing bilingual workers.*
- *Ensuring accessible and affordable mental health care*.

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

Communication

- Communication about changes to practitioners working in this space ranging from practitioners with minimal input to those working in acute settings and frontline.
- Increased communication opportunities between services to maintain confidentiality but allow for clients to have access to support services.
- Community consultation to ensure changes are responsive and appropriate.

Education and professional development

- Continued professional development for all workers working in the mental health field.
- Embed system changes and expectations into degrees/diplomas.
- Community education.

Funding

- Increased funding to develop programs that can be rolled out across the states to make mental health services uniformed.
- Support services that specialise in different areas of mental health.
- Mandated guarantee of service delivery.
- Increased funding and infrastructure.

Recommendation

That the Royal Commission considers the following suggestions:

- *Funding existing services to clear waitlists.*
- *Checking back in with service providers and referral agencies about any proposed changes.*
- *Initiating community conversations/education around mental wellbeing, mental illness and how to access help.*

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

1. About the Monash City Council Submission

Monash City Council (MCC) has many professional staff that:

- Support people at different life stages, such as our Children, Youth & Family Services (including Maternal and Child Health) and Community Support (In-Home Support).
- Screens mental health as part of core business (Maternal and Child Health).
- Makes preliminary assessments and refers people experiencing mental health concerns to relevant service providers.
- Has close contact with different communities within Monash (including Culturally & Linguistically Diverse (CALD) communities, people with a disability and carers) and consults regularly with the community, including for the Municipal Public Health Plan - *A Healthy and Resilient Monash Integrated Plan*.

The MCC submission is based on the expertise and experience of our professional staff, and what we hear from the community.

2. Intersectional approach

Mental Health is a complex problem affected by many overlapping disadvantages and discrimination. Any changes to Victoria's Mental Health System needs take an intersectional approach to ensure that the system is inclusive of, and responds to, everyone in the community (by considering the gender, race, culture, class, employment, sexuality, disability, age, economic and immigrant status).

Attachment One - Figures of service areas referred to in the response to Question 4 of the Royal Commission into Victoria's Mental Health System

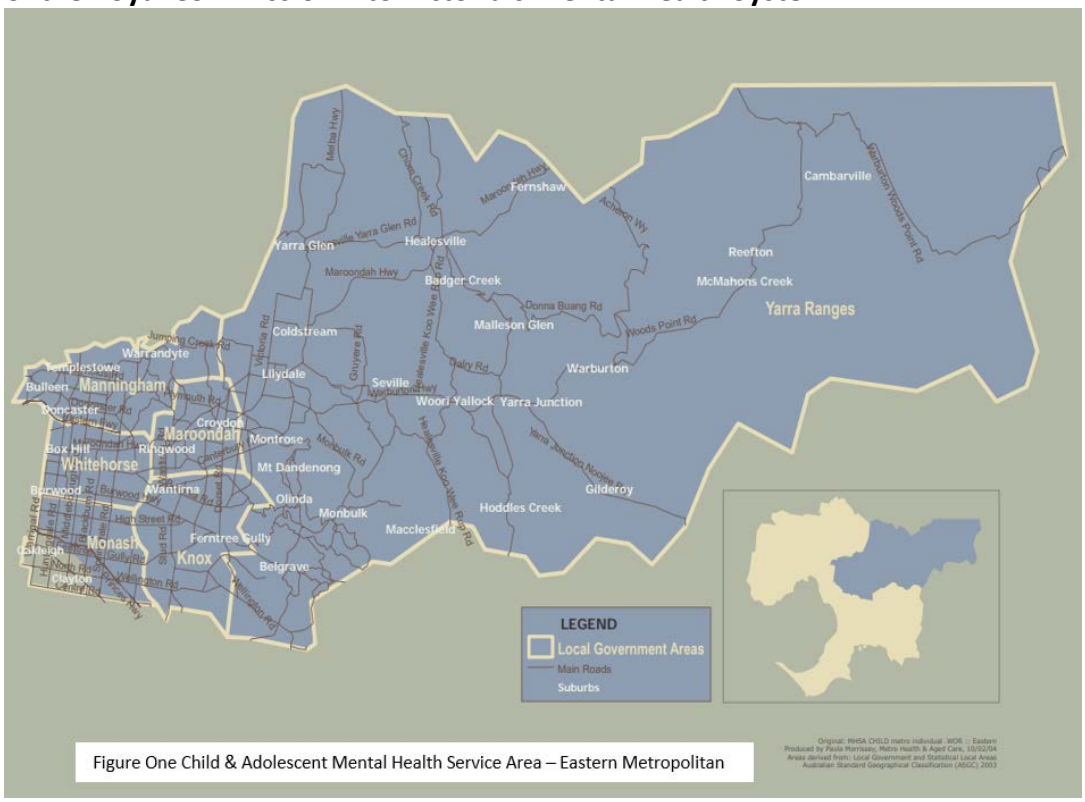

Figure One Child & Adolescent Mental Health Service Area – Eastern Metropolitan

Source:http://www.health.vic.gov.au/mentalhealthservices/child/downloads/child_east.pdf

Figure Two Child & Adolescent Mental Health Service Area – Alfred Health

Source: http://www.health.vic.gov.au/mentalhealthservices/child/map-is.htm

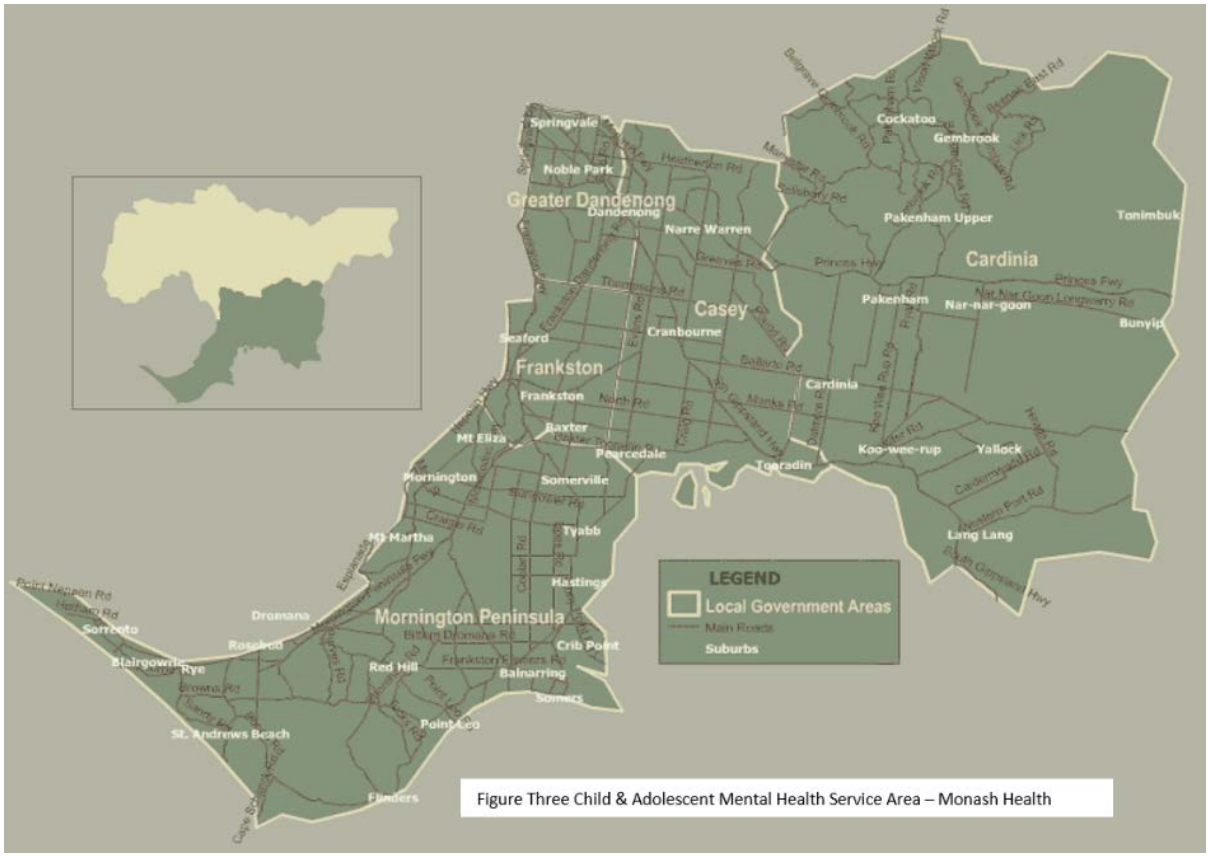

Figure Three Child & Adolescent Mental Health Service Area – Monash Health

Source: http://www.health.vic.gov.au/mentalhealthservices/child/map-se.htm

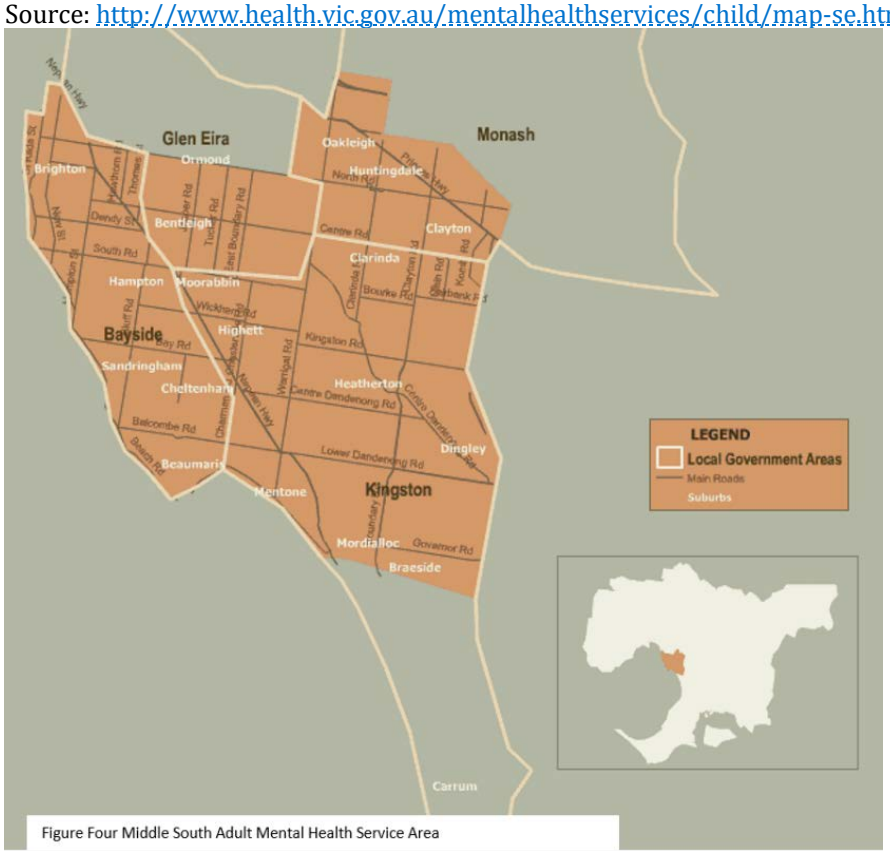

Figure Four Middle South Adult Mental Health Service Area

Source: http://www.health.vic.gov.au/mentalhealthservices/adult/map-ms.htm

Figure Five
Central Adult Mental Health Service Area

Source: http://www.health.vic.gov.au/mentalhealthservices/adult/map-ce.htm

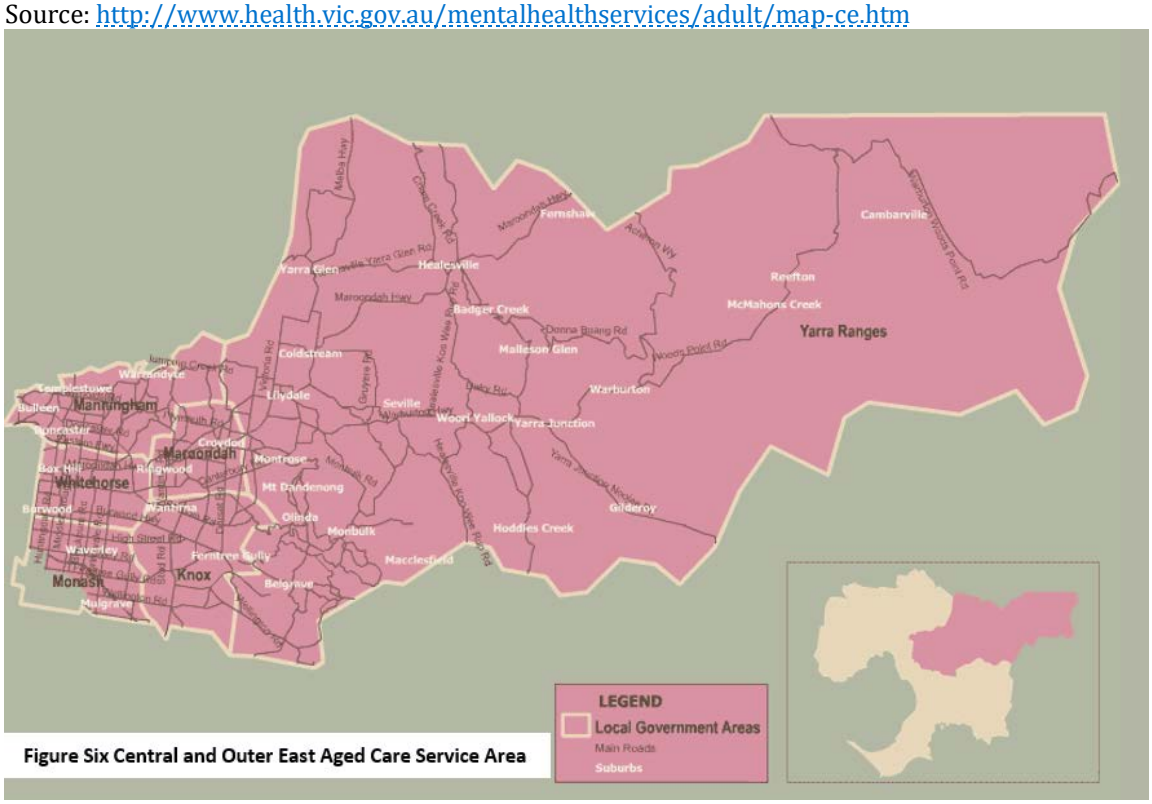

Figure Six Central and Outer East Aged Care Service Area

Source: http://www.health.vic.gov.au/mentalhealthservices/adult/map-oe.htm

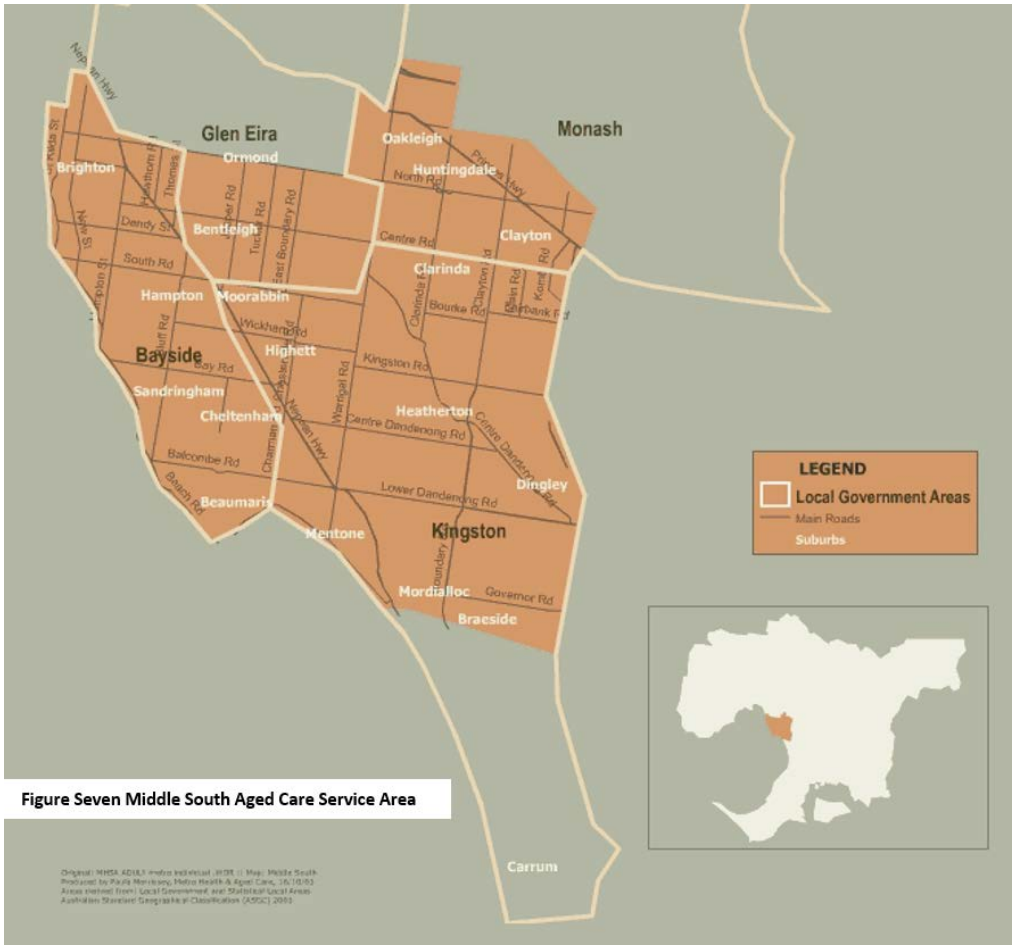

Figure Seven Middle South Aged Care Service Area

Source: http://www.health.vic.gov.au/mentalhealthservices/adult/map-ms.htm

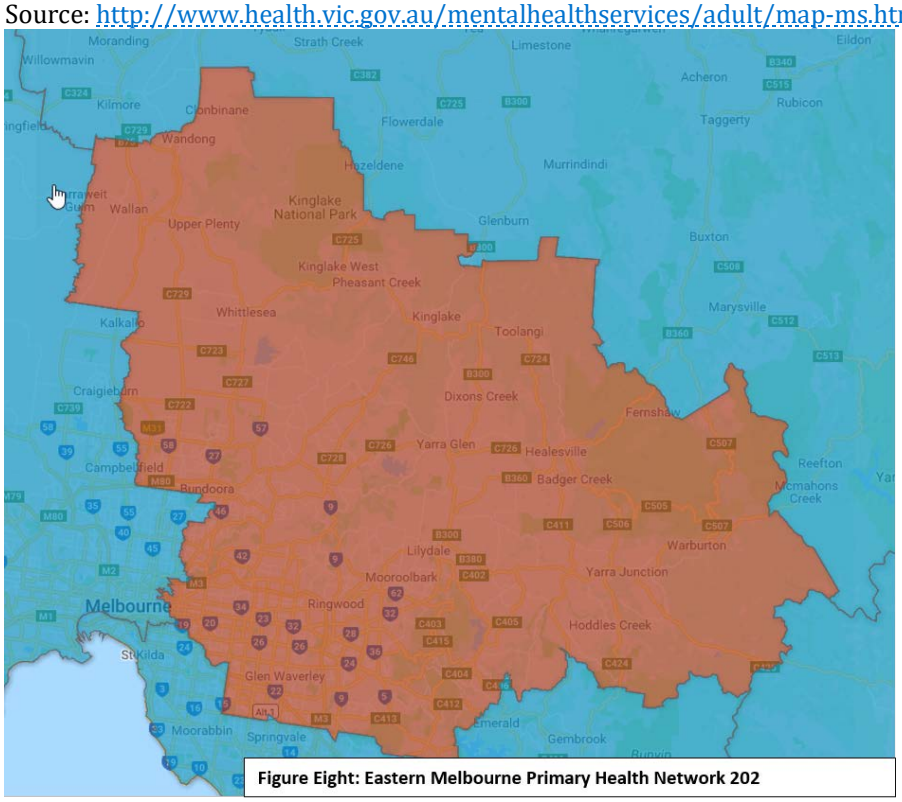

Figure Eight: Eastern Melbourne Primary Health Network 202

Source: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Locator

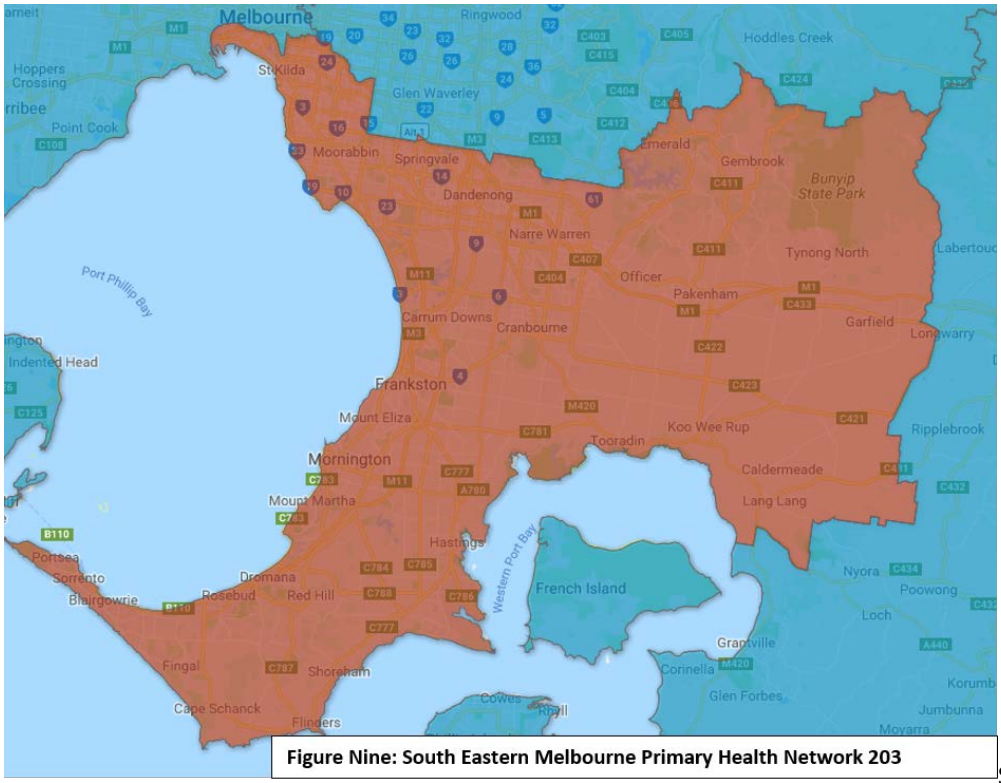

Figure Nine: South Eastern Melbourne Primary Health Network 203

Source: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Locator