Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ANGUS CLELLAND

I, Angus Clelland, Chief Executive Officer and Company Secretary of Mental Health Victoria, of 2/22 Horne Street, Elsternwick 3185, say as follows:

Background

1 I have held senior executive roles in several national and Victorian mental health and disability organisations as follows:

(a) General Manager and Company Secretary of Lifeline Australia (2008 to 2014);

(b) Chief Operating Officer, Guide Dogs Victoria (2014 to 2016); and

(c) Company Secretary, Mental Health First Aid International (2015 to 2020).

2 I am currently the Chief Executive Officer (CEO) and Company Secretary of Mental Health Victoria (**MHV**) Ltd. I have held these roles since 2017.

3 In my role as CEO of MHV, I am a member of several relevant State and Commonwealth committees including:

(a) Co-Chair, Commonwealth Adult Mental Health Centre Technical Advisory Group;

(b) Member, Victorian Mental Health Ministerial Advisory Committee; and

(c) Member, Victorian NDIS Implementation Taskforce.

4 For the past decade, I have also worked as an independent governance adviser, and for the Governance Institute of Australia as a corporate governance lecturer and consultant.

5 My qualifications include:

(a) Bachelor of Economics from the Australian National University;

(b) Bachelor of Science (Psychology) from Monash University;

(c) Master of Business Administration from the Australian National University;

(d) Master of Defence Studies from the Australian Defence Force Academy, University of New South Wales;

(e) Graduate Diploma in Legal Studies from the University of Canberra;

(f) Graduate Diploma in Applied Corporate Governance from Chartered Secretaries Australia; and

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(g) Company Directors Diploma from the Australian Institute of Company Directors.

6 My professional memberships include:

(a) Fellow, Governance Institute of Australia;

(b) Fellow, Chartered Governance Institute, UK; and

(c) Member and Graduate, Australian Institute of Company Directors.

Mental Health Victoria

7 MHV is the peak body for organisations that work within or intersect with the mental health system in Victoria.

8 Our stakeholders include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments and other peak bodies across the health, housing and justice sectors.

9 Our purpose is to ensure that people living with mental illness can access the care they need, when and where they need it. We do this through:

(a) developing policy and undertaking research to improve the mental health system;

(b) promoting system-level and cross-sector thinking; and

(c) supporting organisations through training and professional development services.

10 MHV auspices the Victorian Mental Health Policy Network (**VMHPN**) which brings together more than 25 peak bodies who are major stakeholders in mental health reform. Through the VMHPN, MHV develops comprehensive system policy advice and submissions.

11 I confirm that I am authorised by MHV to make this statement on its behalf. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make the statement based on information provided by others, I believe such information to be true.

Effect of COVID-19 on mental health service delivery in the present and into the future

12 It has been fascinating to watch Victoria and the health system respond to COVID-19. The mental health organisations and workforce have, by and large, responded admirably, with stoicism, grit and determination in the face of adversity. This demonstrates that we

have a workforce that is committed to continuing to deliver the services that Victoria needs.

13 On the other hand, the response to COVID-19 has also demonstrated the fragility of the mental health system. In particular, it has highlighted the fragmentation of the service delivery system and the lack of integration between hospital-based and community-based services. It has also further weakened the already fragile business models of many community based service delivery organisations.

14 Despite this, there are some silver linings that have come out of COVID-19. In particular, COVID-19 has provided an opportunity for individual service providers to think of themselves as part of a bigger system. I consider that a 'famine mentality' has developed over the decades amongst the service providers. They operate with limited funds, under enormous pressure, and have massive and growing demands, which makes it difficult for them to stick their head above the parapet. However, the COVID-19 crisis has forced people to come together in unprecedented ways and to think about what happens outside the boundaries of their own organisation, be it a hospital, a community health organisation or some other form of service provider. This change in how service providers perceive themselves will be useful as the reform process gets underway.

Increased uptake of telehealth services

15 Another silver lining is that the COVID-19 crisis has incentivised the rapid uptake of telehealth by service providers, consumers, carers and families. Historically, there has been very slow uptake of telehealth. This is likely due to the fact that there have been a number of technical barriers to telehealth, through the Medicare Benefits Scheme (**MBS**) or the technology itself, as well as service culture barriers. Now that face to face services are not an option, after an initial slump, we have seen good uptake by both clients and service delivery staff. Specifically, providers are reporting that there has been no noticeable increase in 'no-shows' for appointments that have moved online. New approaches to services, such as substituting four 30 minute video sessions for a two hour face to face session, have ensured that clients receive regular contact and also allowed mental health workers to provide support to a greater number of clients.

16 In the long term, I expect telehealth to be an increasingly important part of the service delivery mix for mental health, particularly if the temporary COVID-19 MBS mental health schedule changes are retained beyond September 2020. Adding telehealth to the service mix into the future will provide a quite effective new delivery mechanism for service providers, particularly in the community setting.

17 In metropolitan Victoria, we are seeing that once individual services start conducting telehealth sessions, they are realising that they are effective. For example, phone or

online sessions help to save time by cutting out travel time for the consumer and the mental health worker who may otherwise have to travel between consumers' homes. Further, there are workplace health and safety benefits to telehealth, including potentially making the supervision of mental health workers more effective.

18 The increasing adoption of telehealth will also be particularly beneficial to regional and rural Victoria. One of the key challenges we face in Victoria and across the country is workforce distribution. Trying to get professional staff outside the inner suburbs of Melbourne is particularly challenging and results in a mal-distribution of the workforce across the State. Regional and rural Victoria really suffer from this inability to attract psychiatrists, psychologists, general practitioners (**GPs**), nurses, and other community mental health workers. In the past, telehealth has been held up as an opportunity to expand the reach of service provision to regional and rural areas, but has had poor uptake. The increased uptake of telehealth after COVID-19 will potentially mean there is a more frequent and regular offering for clients in these parts of the State into the future.

19 This would also be helped by the establishment of state-wide digital mental health services for young people and adults. These services would be staffed by multidisciplinary teams that could use telehealth to reduce some of the pressure on 'physical' area health services and to reach into underserviced parts of the State. Such services would ideally be accessible through the Commonwealth's new Adult Mental Health Centres (**AMHC)**, which will begin rolling out nationally from 2021. I discuss AMHCs in more detail from paragraph 80.

20 I should note though, that accessing telehealth requires access to good quality internet services and this can be difficult for people in regional Victoria and vulnerable people in all areas.

Leadership

Capabilities and skills to drive and oversee reform

21 First and foremost, we need leaders who are committed to a 2030 mental health and wellbeing vision for Victoria, and who can plan for reform at both a system and individual service level. This reform vision needs to be articulated and modelled at all levels of leadership: the Premier, Ministers, Departmental Secretaries, CEOs, service divisions and individual work units.

22 Leaders need to have a very strong commitment to multi-disciplinary care and understanding of the importance of team-based approaches for delivering care to individuals. As mentioned above, one of the biggest challenges we face is the lack of integration and the fragmentation of services. This means we need leaders who are able to look beyond their particular profession or organisational business unit and understand

that a mental health response is not just about treatment or the delivery of a particular service.

23 Good leaders also need to build the culture of their business units or organisations to help them to embrace and commit to transformation and change. This will involve collaboration with different sectors and different organisations. I often use the example of the VMHPN, which has brought together clinical directors and secretaires of unions (amongst others). Normally, these parties would be on the other side of the table, fighting with each other about industrial issues. However, within this context, they actually have a common interest in system reform and workforce reform. Being able to set aside some of their other issues and work on this common interest is particularly important. I describe the collaborative nature of the VMHPN's work further below.

24 Good leaders also need to be able to identify talent, develop others and commit to supporting them. They also need the skills to support research, innovation and management across the entire system. In short, we need people who are systems thinkers, good change managers, can work on the culture and bring different people and stakeholders together.

25 To help support leaders to develop the requisite capabilities and skills, leadership capability development programs should be funded and delivered across the State. The development of emerging leaders should also be formalised as a function of or a key performance indicator within leadership roles and practice.

Example of effective domestic leadership

The Victorian Mental Health Policy Network (VMHPN)

26 The VMHPN came into being in April 2018 as a response to the crisis within the mental health system and out of a desire to change the narrative around reform of the system. Rather than just advocating for reform on the basis of human rights or a health response, we considered it necessary to look at the economic aspects of reform. To do so, we brought together a broad group of stakeholders – including peak bodies, unions and others – to get their buy-in and a shared commitment to working together. That formed the basis of a publication called *Saving Lives, Saving Money*, which has been supplied to the Royal Commission. The publication put forth an economic argument as to why we needed to reform mental health in Victoria.[1]

[1] Mental Health Victoria (2018) *Saving Lives, Saving Money: the Case For Better Investment in Victorian Mental Health* <https://www.mhvic.org.au/images/PDF/Policy/FINAL__Saving_Lives_Money_Brochure_HR.pdf> [accessed 2 June 2020].

27 The VMHPN subsequently became a standing body which meets every one to two months to talk about mental health reform, share the issues facing each of the various stakeholders' sectors and collaborate on policy development and advocacy work. This collaboration has strengthened the idea at peak body level that there is a common interest across all of these different organisations and aspects of Victorian life. We think that it is useful to have, for example, the Royal Australian and New Zealand College of Psychiatrists sitting side by side with the peak Victorian bodies for consumers (VIMIAC) and carers (Tandem), as well as unions, and peak bodies for police, nurses, housing and homelessness. All of those different organisations bring together their own perspectives on mental health and the reform process, all of which are valid and need to be considered.

28 As a specific example, we made a joint submission to the Royal Commission between ourselves and the Victorian Healthcare Association (who represent the hospital system in Victoria). In the past, there has been a philosophical separation between mental health services in hospitals and mental health services in the community which has hindered collaboration. It is important and effective to gather these perspectives in one document.

29 The VMHPN recognises that, when these organisations are working together, our advocacy is more effective and there is greater political clout and receptiveness. The reality is that mental health has been, up until very recently, viewed as the 'poor cousin' of the health system and not as a political issue. As the establishment of this Royal Commission demonstrates, mental health is now very much a political issue, but one that should be above politics. This is, at least in part, a result of the individual and collective advocacy efforts of mental health organisations over many years.

Example of effective international leadership

Overview of the Trieste model

30 The Trieste model (named for the town of Trieste in north-eastern Italy) is a great example of effective international leadership driving enduring reform. The driving force of change in Trieste started with the work of Franco Basaglia who was Director of the San Giovanni psychiatric hospital from 1971 to 1980. After he passed away in 1980, Roberto Mezzina took over and led the work of the Trieste model until the end of 2019.[2] I had the opportunity to meet with Dr Mezzina in Italy in 2019 before he retired and to participate in an international study tour of the Trieste mental health system.

31 The process of deinstitutionalisation started in Northern Italy in the 1970s and really kicked off in 1980 when they shut the San Giovanni Mental Hospital. After this, there was a movement towards open door care and community-based support for individuals.

[2] Mezzina, R. (2014), Community Mental Health Care in Trieste and Beyond: An "Open-Door-No Restraint" System of Care for Recovery and Citizenship, Journal of Nervous and Mental Disease, 202(6) 440-445.

Rather than locking up people with mental illness, the idea was to move to a model that emphasised the individual in the community, ensuring that their needs for housing, employment and mental health care were met whilst also protecting their individual rights.

32 Over time, the Trieste model has coalesced around four Community Mental Health Centres (**CMHCs)** which each service a catchment area of between 50,000 and 65,000 people and operate 24 hours a day, with four to eight beds in each. There is also a very small hospital department with a mobile crisis team that has approximately six beds. This is a very low hospital bed to population ratio, relative to Australia. There is also a housing service which provides secure housing in group homes and supported housing facilities. The focus of the Trieste model is on keeping people safe and well within the community. This does not mean that hospital based services are not important, just that they are weighted differently.

33 The CMHCs in Trieste are open 24 hours and are drop in centres. People can walk in and out of the centres as they please and stay overnight if required. There are very low rates of compulsory treatment, lower rates of suicide relative to other parts of Italy and Australia and very low rates of presentation to emergency departments. Individuals have personal healthcare budgets which helps them to tailor individual recovery and social inclusion plans of care.

34 The mental health centres are staffed by a multi-disciplinary team comprised of nurses (the majority), social workers, psychologists, rehabilitation specialists, and psychiatrists. Staff rotate or can rotate between the hospital and the centres. This is important as staff get to see and understand people in the context of a clinical hospital setting, and in the community, which can help to develop relationships.

35 One of the reasons that the Trieste model has been so successful is that there is quite a large surplus of housing stock in Trieste. Individuals predominantly receive support in the home or supported accommodation. Secure housing, along with employment, are absolutely critical contributors to mental health and wellbeing. The stresses associated with housing insecurity and unemployment have a very negative affect on the general population and especially on individuals living with mental illness. It is vital that access to secure housing is included in the future service model for Victoria.

36 The Trieste model has been held up as an international model and benchmark – it is recognised by the World Health Organisation as the model for mental health treatment and support. I think it is an incredible example of what can happen post deinstitutionalisation with a strong political commitment to reform.

Attempts to replicate the Trieste model

37 There have been attempts to replicate the Trieste model in other places such as Los Angeles. However, replicating the model is difficult because the levers available in Trieste are not necessarily available elsewhere: if you cannot provide safe and stable housing for people, then the model tends to not to work as effectively. Certain aspects of the model, such as the integrated care and a team-based care approach, have been implemented in many places. However, I do not think the full model has been successfully implemented anywhere else.

38 The reality is that the Trieste model is not a franchise that can just be dropped into place somewhere. Rather, we have to take parts of the model that would work effectively within the Victorian or Australian context, noting our own challenges around responsibility sharing between the Commonwealth and State governments. In light of this, I think we should move towards community based multi-disciplinary care that works hand in glove with the hospitals and supports people either in a community mental health centre or preferably in their own homes.

Governance

Establishment of a Victorian Mental Health Commission

39 In our submission to the Royal Commission, we have recommended the formation of a Victorian Mental Health Commission (**VMHC**). The governance of the mental health system is incredibly complex and we believe it needs an overarching, independent body to pull together all of its elements, both Commonwealth and State funded. A well-resourced independent body sitting at the top of the system will reduce the risk that reform will stall once the momentum of this Royal Commission wanes and political focus inevitably shifts away. The VMHC can act as the capstone of system governance and provide oversight, support the development of new service models, support innovation and snap at the heels of politicians, government departments and service providers.

40 At the moment, there is no centralised approach to governance. We have too many chiefs, which has resulted in a patchwork and fragmented system. We have seven different mental health plans for the State: one Victorian Government plan and six Primary Health Network (**PHN**) plans. Even if we combine all of these plans together, we still don't have a single plan for the State as each plan is devised largely in isolation of the others. This adds to the risk that many communities will miss out, with one population group prioritised in one region and not in another. In addition, the existing plans generally lack targets and success measures. This approach to service planning makes it incredibly hard for individuals to access the services that are actually available, and to have a good experience of the service system.

41 The creation of a VMHC will help to reinforce the criticality of mental health as a strategic investment for the State. The interim report of the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health (**Productivity Commission Inquiry**) states that poor mental health costs Australia $180 billion per annum.[3] This is the equivalent of more than 10% of Australia's GDP. Spending on mental health should therefore be viewed as an investment, as keeping people safe, well, housed, employed, paying taxes and contributing to the economy has major economic, social and health benefits. Anything that we can do and any investment that we make will have a large economic return.

42 The staffing of the VMHC should consist of a diverse range of people, including people with a variety of lived experience. Formal structures also need to be established to ensure that people with diverse lived experience are engaged at the start of policy development and the system design process. The VMHC also needs to formally recognise and integrate consumer, family and carer peer professionals in all settings and parts of the workforce.

43 The design of the VMHC can also address specific objectives such as suicide prevention without creating new entities. There are a number of structures already in place that can be drawn on to assist a VMHC in that role, for example, existing peak bodies for suicide prevention and for carers and consumers.

Functions of the VMHC

44 I believe that a VMHC should:

(a) act as a system leader with responsibility for strategy development and performance monitoring;

(b) provide independent oversight of commissioning bodies and report to Parliament;

(c) provide independent expert advice to commissioning bodies and governments on any matters relevant to mental health, addiction and wellbeing;

(d) be able to cut-across portfolios and not be restricted to the Health portfolio;

(e) advocate for the collective interests of people with mental health and addiction challenges and their families;

(f) drive change while bringing others along, with a focus on the need for innovation and best practice;

[3] Productivity Commission, Australian Government, Mental Health Draft Report: Overview & Recommendations (October 2019) 2.

(g) promote cross-sectoral collaboration, communication and understanding about mental health and wellbeing across mental health, justice, housing and other relevant sectors; and

(h) drive health prevention and promotion efforts across the Victorian population.

45 Complaints could be incorporated into the role of the VMHC, although I note there has been a shift to place mental health complaints and disability complaints under a single Commissioner.

46 It is important for there to be a separation between system governance and system management. Oversight direction, strategic planning, target setting and monitoring should be separate functions of the VMHC. However, I do not think that the VMHC should be involved with commissioning and implementation, as sufficient separation is necessary for the VMHC to have proper oversight of this process. Management of individual service providers can be left to the service commissioners.

47 The challenge, of course, is that if the VMHC would only be in a position to commission Victorian-funded services and not Commonwealth funded services. We prefer to see co-funding and co-commissioning as being one of the pathways for bringing the Commonwealth and the State systems together.

48 A particularly important function is independent oversight: we need to have an independent organisation that can report to Parliament across a range of portfolios. Mental health is not just a health issue; it can also affect the justice, education and housing portfolios. For example, schools often employ counsellors or mental health workers and deliver large scale mental health programs. The VMHC should be able to have oversight across all of those areas. It should set mental health and wellbeing key performance indicators (**KPIs**) for all portfolios, and evaluate, report on and monitor performance against those KPIs. In this way, the delivery of mental health reforms would effectively become the shared responsibility of every Minister and Department Secretary.

49 The VMHC would also need to be involved with data analysis, health economics, evaluation and research. There is a huge amount of data out there – some publicly available, some not – but also many gaps. There is no complete picture of mental health across the entire Victorian State and population. Between the Department of Health and Human Services, the Australian Bureau of Statistics and the PHNs, we are not short of data to help us plan for the future. Being able to draw all the existing data together would be incredibly useful, and would also help to determine the factors that would impact on the success of mental health reforms, such as demographic shifts.

50 I discuss the importance of monitoring, reporting and oversight in the context of quality, safety and commissioning at paragraphs 133 to 141 below.

Collaboration with other bodies

51 The VMHC needs to work very closely with the National Mental Health Commission (**NMHC**), noting that the role of the NMHC is being considered in the Productivity Commission Inquiry so that may change and evolve. Alongside our recommendations for a VHMC, we are supportive of a bigger role for the NMHC. However, having the two bodies working closely together is essential; it would help to address many issues in bringing the Commonwealth and State approaches together and bringing a whole-of-population approach to mental health.

52 We would also expect that the VMHC would work very closely with the new Victorian Collaborative Centre for Mental Health and Wellbeing, which is Recommendation 1 of the Royal Commission's Interim Report.

Community based mental health system

Trends and changes that could dramatically alter the need for mental health services or the provision of mental health services

53 Forward planning for Victoria's mental health system should take into account population, socio-demographic and geographic trends. Making changes to the system on account of these trends will require integrated and intergovernmental infrastructure, workforce and service planning, as well as emergency response plans that consider potential mental health needs across the State.

54 Of course, given what we have seen so far in 2020, we need to plan for pandemics and natural disasters. We also need to consider climate change and its long terms effects.

55 In addition, we need to factor in immigration patterns. The mental health of certain populations is related to the migration experience, particularly where there is a history of trauma, employment problems and language difficulties. For example, refugees and people fleeing from different parts of the world are at higher risk of mental illness and have particular needs and associated trauma.

56 The State's urban and environmental planning plans and strategy should also be taken into account. For example, some outer suburbs and growth corridors can lack social and community infrastructure, employment and public transport, which are risk factors for social isolation and poor mental health.

57 We also need to consider the specific needs of Victoria's various culturally and linguistically diverse (**CALD**) and/or vulnerable communities. For example, in my experience, the needs of the non-English speaking population and older Victorians are often overlooked as part of the system response.

58 Trends in imprisonment also need to be factored into the mental health system plan. Early intervention is particularly crucial with young people involved in the criminal justice system and with Aboriginal and Torres Strait Islander (**ATSI**) people, who have a much higher rate of imprisonment.

59 Further, Victoria's increasing homelessness rate and trends among the homeless population are likely to considerably impact the need for mental health services and their design. People who are homeless are at high risk of developing mental illness and people who have mental illness are considerably more at risk of becoming homeless.

60 Attitudes around race, gender and sexuality can also affect mental health outcomes. A disproportionate number of Victorians experience poorer mental health outcomes and have higher risk of suicidal behaviours. Health outcomes are directly related to trends in social attitudes which can stigmatise, prejudice, discriminate and abuse people on the basis of their culture, language, race, gender and sexuality. Social trends impacting women and girls, CALD communities, people of colour, ATSI people, LGTBIQ people and other such diverse communities will have relevance to planning for mental health services.

61 The needs of these vulnerable groups should be heard with regard to their own lived experiences and not unstated assumptions about what their needs are. There is also a significant role for skills *within* those communities to be drawn upon to assist those *in* those communities. For example, the efficaciousness of the professional relationship is improved when you are explaining aspects of your own sexuality to a service provider with the same experience or knowledge of sexuality.

62 We also need to consider trends in relation to:

(a) technology;

(b) alcohol and other drug related harms;

(c) family violence, child abuse and home care;

(d) unemployment and intergenerational disadvantage and inequality;

(e) an ageing population;

(f) increasing rates of mental illness in youth; and

(g) understandings of suicide and suicide prevention.

63 Looking at these future trends and changes, we need to ensure that there is a consistent set of core services available to *all* Victorians. Your location and socioeconomic status should not determine the quality of care that you can access and receive. I discuss this further in the context of commissioning from paragraph 137 below.

64 However, not all care or support options suit all people, and mental health service delivery needs to be tailored to local needs and local context. For example, in Dandenong, where there is a large migrant non-English speaking community, services will need to be tailored for the specific needs of that community.

Design of the community-based health system

65 As stated in our initial submission to the Royal Commission, community mental health services should be based on the following principles:

(a) A collaborative, human rights approach;

(b) A person centred, holistic, integrated approach;

(c) A qualified, multidisciplinary workforce;

(d) Services across the lifespan;

(e) Services across the range of experiences of illness, wellness and recovery;

(f) Evidence-based treatments;

(g) Accessible, multi-modal services delivered in the home, online and in community centres; and

(h) In-built quality improvement.

66 Community-based services can be delivered at considerably lower cost than hospital-based mental healthcare services, although neither is a replacement for the other. We need to ensure that investment is appropriately balanced between services to ensure the optimal benefit for individuals, families and carers, and the State. We need to set access, quality and outcome targets to be worked towards which can be monitored by a state-wide oversight body like the VMHC.

Best practice models

67 In my experience, the key to implementing a successful community based model is the leadership and commitment of the organisation. There are a number of best practice models for community based mental health care in Victoria. I discuss three examples and a model from Queensland below.

First Step

68 One example of best practice is First Step in St Kilda. First Step offers multidisciplinary team based services spanning mental health, alcohol and other drugs (**AOD**), physical health services and in-house legal. First Step practitioners include GPs, addiction medicine specialists, psychologists, AOD counsellors, lawyers and family therapists.

69 Critical to the success of First Step is a fully integrated community legal centre with lawyers who specialise in criminal and family violence law. This is important as most clients present with multiple high-level intersecting needs, such as addiction, mental illness, homelessness, social isolation and legal issues. The majority of clients have complex histories, including childhood sexual and physical abuse and neglect. Central to the care provided at First Step is the collaborative work of non-clinical and clinical staff. A core component of the model is case conferencing to obtain detailed histories and achieve accurate diagnoses and workable, client-led treatment plans.

70 The First Step funding model is also largely reliant on philanthropy and the MBS. I think part of the reason for First Step's success is the fact that it is largely philanthropically funded. This funding model helps to foster innovation and ensures that the organisation has not been constrained by a multitude of service contracts with a multitude of different government agencies. The downside is that philanthropists tend to avoid funding business-as-usual activities which creates sustainability issues for the organisation.

McAuley Community Services for Women

71 McAuley Community Services for Women is another good example of a community based health service. This service is for women and children who are homeless and are fleeing domestic violence and family violence. They work with around 1000 women and children a year and around 65% of those women have mental health issues.

72 McAuley's model of care is particularly relevant: they take a holistic view of each woman (and her children) and place them at the centre of care. Further, they encourage multi-disciplinary and cost-effective approaches. They provide primary care, housing services, case management, social and independent living skills, and have partnerships with financial, legal, general, mental health and disability expertise, allowing them to achieve cost effective, scalable outcomes. The effectiveness of McAuley's service model has been evaluated by Deloitte Access Economics, who concluded that the services McAuley provides generate positive social and economic returns.[4]

Safe Haven Cafe

73 Safe Haven Cafe was implemented by St Vincent's Hospital to provide an alternative non-clinical service to the Emergency Department (**ED**). It is based on a UK model. The Safe Haven Cafe in Melbourne has now been open for two years and is staffed by social

[4] See Deloitte Access Economics, *McAuley Community Services for Women: Annual Evaluation Report, Year Two FY19* (Report, October 2019) <https://www.mcauleycsw.org.au/wp-content/uploads/2020/01/Evaluation-report-Financial-Year-2018-2019.pdf>; Deloitte Access Economics, *McCauley Community Services for Women: Social Return on Investment* (Report, October 2019) <https://www.mcauleycsw.org.au/wp-content/uploads/2020/01/Social-Return-on-Investment-October-2019.pdf>.

workers, peer support workers and volunteers. The cafe has seen 1500 people already and the number of people accessing the service is steadily increasing.

74 The cafe does not brand itself as a 'mental health' facility; instead it is a place where someone experiencing psychological distress or feeling isolated can come and spend some time, have a coffee, talk to someone, get some information and get some extra care if they need it. This is primarily a non-clinical approach (although there is a clinician available) providing a safe and comfortable space for people to present to, or to wait in following presentation to the ED.

75 The cafe provides people with information on available services outside the cafe, however, will only provide assistance with accessing those services if the person is having difficulties. Peer support workers arrange connections with other services.

Floresco Integrated Service Hub

76 The Floresco Integrated Service Hub (**Hub**) is an adult mental health service operating in Ipswich, Queensland, in the West Moreton Hospital and Health District. It was established in 2014 through a consortium of four non-government organisations, including two mental health support providers, a disability service provider, and a tenancy advice and advocacy service. The Hub delivers non-clinical community-based mental health services, including personalised support, mutual support and self-help, group support and family and carer support. In addition to these services, the Hub has been designed to simplify access to a range of other services including general practice, psychology, and social work.

77 The Hub service model was evaluated by the Queensland Centre for Mental Health Research and the final report was published in January 2019.[5]

78 The evaluation showed that the integrated service model contributed to positive mental health outcomes for clients with significant mental health and functional difficulties. In addition, of those study participants who had reported high rates of suicidal ideation in the 12 months prior to their engagement with the Hub, reported significantly lower rates afterwards, with almost two-thirds of participants reporting no suicidal ideation during the six months between their baseline and follow-up interviews.

79 The evaluation also showed that there were a number of challenges to providing an integrated model of care. These included staff recruitment and retention; information

[5] See Beere, Diana, Page, Imogen S., Diminic, Sandra and Harris, Meredith (2018). Floresco service model evaluation: final report 2018. Brisbane, QLD, Australia: The University of Queensland, Queensland Centre for Mental Health Research.

sharing; integrating with the public mental health service; responding to higher than anticipated demand; and the complexities of operating in a consortium model. [6]

Adult mental health centres

Creation of adult mental health centres

80 Services are in short supply across the mental health system and are often difficult to access in the community setting. There are generally few services for individuals, families and carers beyond general practice and often the only alternative is to present to hospital emergency departments. It is critical that this 'missing middle' is addressed: this will require collaboration between governments to bridge the gap between MBS funded services (GPs, Better Access) and the Victorian hospital system. Part of the solution lies in the establishment of a network of highly accessible and visible community mental health centres across the state.

81 Communities, interest groups and local councils around Victoria and across the country have long been asking for the establishment of mental health and wellbeing community hubs or centres. We were therefore delighted when the Commonwealth, after considering a joint proposal from MHV and Australians for Mental Health, as well as similar proposals from several other States, agreed to fund a $114.5 million trial of eight Adult Mental Health Centres (**AMHCs**) over 2020-21 to 2024-25, including a centre in Geelong. This is a strategically significant investment that will begin to address a major gap in Australia's mental health service system architecture.

82 As mentioned above, I am the Co-Chair of the Commonwealth's AMHC Technical Advisory Group. As such, my comments are limited to the publicly available information on the AMHCs, noting that the draft service design will be shortly released for national public consultation.

83 As outlined in the Commonwealth's budget papers, the AMHCs will provide mental health support services over extended operating hours. People seeking help will have access to on-the-spot treatment, advice, and support provided by a variety of mental health professionals – without needing a prior appointment. The centres will ensure that people are provided appropriate immediate support and are connected to pathways of longer-term care by integrating with other local community services including GPs, local PHN services, and state-operated services. They will also be able to assist people to access related health and social services. It is expected that the centres will reduce the number

[6] Ibid.

of emergency department presentations by providing a more accessible entry point to the mental health system.[7]

84 The core aim of AMHCs is to provide an open and welcoming space for people to go to, which will also help to destigmatise mental health services. Most of us think nothing of going to the local medical centre or general practice to get our physical needs taken care of – hopefully one day we will get to the point where going to the local mental health centre is no different. As such, the AMHCs will be highly visible and branded and advertised, with clear information about 'where to go and what is available', not just a simple direction to 'seek help'.

85 The public demand and need wrap-around services. The establishment of AMHCs in the community should present an opportunity for the Victorian Government to co-commission services and make them accessible through the Centres. In doing so, this would expand the service offering of each centre and take us closer to the ideal of providing a full suite of wrap-around services for individuals, their families and carers.

86 Outreach is also important, but we need a focal point from which we can outreach into houses and accommodation for people who can't present at a community centre. This ties back to the Trieste model discussed above at paragraph 30, as it gives people the opportunity to have their needs met by attending a centre or receiving support at home.

Challenges for community-based mental health care – workforce and demand

87 Like all of the reforms needed to the mental health system, the success of initiatives like the AMHCs will depend on the workforce. Being able to appropriately staff and deliver new or expanded services will be a challenge and will need to be considered as part of a ten year (or longer) vision that we need to consider. I discuss these challenges further below from paragraph 114.

88 Demand management will be a key issue for AMHCs. Part of the challenge with the initial rollout of these services is the prospect of being swamped early on with demand. However, our hospitals, community health organisations and community mental health service providers are very good at managing demand and determining when they need to deploy resources at appropriate times.

89 Demand will also depend on the operating hours of the centres. To be effective, AMHCs will need to be open seven days a week with extended hours. I suspect, however, that after hours, hospitals will be the default entry point.

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[7] Australian Government, 'Budget 2019-20: Prioritising Mental Health – Adult mental health centres' <https://www.health.gov.au/sites/default/files/prioritising-mental-health-adult-mental-health-centres_0.pdf> [accessed 2 June 2020].

90 For example, in Trieste, after 10pm the entry point into the mental health centres is through the hospital. People are supported at the hospital and then in the morning they are transported to the community-based centres. There is a strong emphasis on partnership and pulling various parts of the system together for the benefit of the consumer and the family.

Collaboration between Commonwealth and State governments

91 In many ways, community-based mental health care services like AMHCs will help solve economic problems common to both the Commonwealth and the State. If there are insufficient services available, individuals will go to hospital EDs, which is costly for the State. If the AMHC program is implemented effectively, then the State will benefit and there would be a lower cost response to the mental health needs of individuals.

92 There would also be broader benefits to the economy, in terms of workforce participation, productivity, extended lifespan and taxation revenue. We believe that if individuals are supported within the community, there is a greater likelihood that they will hold down a job, buy a house, have a mortgage, pay taxes and be able to purchase goods and services.

93 Part of the challenge, of course, is that we have part of the mental health system funded by the Commonwealth and another part funded by the State. As I mentioned above, the two parts of the system do not come together particularly well.

94 There are clearly a host of benefits associated with collaboration. At the moment, because the mental health system is so fragmented, the consumer loses out. If, for example, you did an internet search for "mental health services" or "help near me", you would be overwhelmed with websites about individual providers and government agencies that you probably have not heard of before. It is really difficult to know where to start. We need to reform the online environment so that the entry point is easy for people, whether it is through the GP, a community mental health centre, online or from home – people should be able to start that search process and have a good customer experience.

95 In order to ensure the success of AMHCs, the Victorian Government should get on board with the program, and require that State services are co-located with or accessible through these system entry and service delivery points.

Relationship of AMHCs with PHNs

96 The PHNs will undertake the commissioning, local design and local engagement in relation to AMHCs. There will need to be is a strong partnership arrangements in place at a local level with, for example, consumer groups, community service providers, and the local area mental health service.

Service integration

97 The key test of successful integration is that the service user or the consumer does not notice the division – it should be a near seamless, non-bureaucratic and un-stressful experience. It should be irrelevant to individuals which body commissions or funds the service, provided they get the support that they actually need. The critical feature is to have a system that is easily navigable for individuals, to ensure they get the wraparound care that they actually need. That means ensuring that primary care, acute care, physical health and AOD services are all wrapped up in a package for individuals.

98 In order to encourage integration, we need to create cultural change within organisations, such that they have a willingness to partner with external organisations. We also need to make sure that the internal divisions within a particular service provider are broken down and ensure there are practices such as case conferencing.

99 There are other reforms which may be helpful, such as reforming the MBS to incentivise integration as well as providing more support and training in mental health for GPs. In addition, GPs should be encouraged to prioritise mental health whilst looking at other issues. For example, there could be an incentive to prepare a mental health plan at the same time as doing a physical health check, looking at the patient's history of addiction and other issues.

100 As discussed above, the VMHC will be key to achieving integration. However, individual organisations also need to take responsibility for providing integrated care. One option is to use the service and funding agreements to mandate integration and include KPIs that are reported on and monitored to encourage the necessary level of collaboration.

The importance of workers seeing themselves as 'whole person health workers'

101 As mentioned above, the fundamental problem at present is the fragmentation and break up of service delivery for individuals. The move towards multidisciplinary team-based care is part of the solution; it is very well recognised, desired and demanded by consumers, family groups and the various professions involved in mental health care. We need to break down barriers between service providers: for example, just because you are providing housing services for homeless people, that does not mean you should not also be working collaboratively within a team-based environment with a mental health service provider within your local area.

102 We can achieve this multidisciplinary collaboration by incentivising and rewarding providers for delivering integrated care. I see the Collaborative Centre for Mental Health and Wellbeing (**Collaborative Centre**) having a particularly crucial role in modelling and reinforcing ways of working collaboratively.

103 As discussed above at paragraph 14, one result of COVID-19 is that people are now thinking about the bigger picture and understanding that if they do not do their work effectively and deliver appropriate services, it will have a flow on, cascading effect throughout the system.

104 One place where I have observed an effective team-based approach is Star Health. Star Health is a service provider in the South Eastern part of Melbourne CBD area. They are a community health service with a number of different primary care and mental health programs. Star Health works in collaboration with the Alfred Hospital, effectively modelling a team-based approach.

105 We could help to change the system first through achievable pilots, where the system is completely reimagined and enacted holistically to design, establish and train-up the workforce to respond to the person as a whole. Several metropolitan, regional and rural areas could be selected. Local community organisations, hospitals and relevant PHNs would be involved. The aim is that workers and service delivery models, even where they have specialities, see themselves primarily as 'whole person health workers' and are funded and administered this way. From successful pilots it is possible to over time re-orientate the whole system that way and spread new ways of working. I discuss other challenges facing the mental health workforce below from paragraph 117.

Understanding and treating the mental health needs of young Victorians

106 Victoria needs to prioritise funding for community based youth specialist services. This funding needs to develop packages of care that are designed to:

(a) provide evidence based treatment;

(b) provide wraparound services and supports tailored to the needs of the individual, including physical and mental health needs; and

(c) partner with the Commonwealth through co-investment in community platforms.

107 We also need to support our GPs to identify and address the mental health needs of young people through training, professional development and MBS reform. When children become mentally unwell, their parents' first port of call is often their local general practice. At the moment, GPs struggle with training, referral pathways and a lack of integrated care.

Families and carers

Embedding family-inclusive practice and the challenges or barriers for services working in a relational context

108 Organisations such as Tandem and Carer's Victoria are the experts on family-inclusive practices, but I can approach this matter from the perspective of service delivery.

109 There is a challenge in terms of acceptance of family-inclusive practice for various service providers across the State. I consider this is partly an issue due to the famine mentality I discussed above at paragraph 14. Being starved for resources has meant that people in the mental health workforce work very hard in difficult circumstances, so a family-inclusive response is not always front of mind. Many service providers also do not feel adequately trained in family-inclusive practice.

110 In addition, services and training have traditionally been organised around an individual treatment model. We need to encourage people to think about the way that services are delivered and the need to think about the broader family unit, bearing in mind that the family unit may also be part of the problem.

111 There are standards for family-inclusive practice in Victoria but they are not compulsory for service providers to follow.[8] There is always a risk with voluntary standards that organisations will not implement them.

112 In addition, confidentiality and privacy laws limit the information that can be provided to family and carers, and they are often seen as limiting the scope for family-inclusive practice. Family members can often become frustrated at not being provided information or not being included in service delivery responses. This, in turn, can lead to family members being labelled as 'interfering' or 'difficult', which compounds their exclusion.

113 The National Disability Insurance Scheme (**NDIS**) is also not well set up for the inclusion of family in the process and in service delivery. NDIS procedures and policies do not adequately take the perspectives and needs of carers and families into account, and NDIS plans do not fund services for carers.

[8] See Mind Australia, Helping Minds, Private Mental Health, Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia, 'A Practical Guide for Working with Carers of People with a Mental Illness' < https://mhaustralia.org/sites/default/files/docs/a_practical_guide_for_working_with_carers_of_people_with_a_mental_illness_february.pdf> [accessed 2 June 2020].

Workforce

Significant issues currently facing the workforce

114 Even when budgets allow, it is often difficult to fill the positions that are funded. This is partly due to the secondary priority that mental health is often given in organisations. For example, clinical directors often tell me that a hospital recruitment freeze means that they cannot fill a particular position in the mental health area, and then once the financial year rolls over, funding for that position will disappear.

115 Policy decisions such as the transfer of consumers from State-funded services to the NDIS have also created an unintended exodus of experienced workers to other sectors, which creates widespread attrition of capability and skills built over many years.

116 Most importantly, we need to move to a state where mental health is seen as an attractive profession and desirable specialisation. Decades of under-resourcing coupled with ever increasing demand for services has made mental health an unattractive career option for many.

Designing a workforce for the future

117 In order to design the future mental health workforce, there first needs to be a plan and vision for the State through to 2030, which the VMHC would have a role in setting. The planning process will eventually get down to a local or regional level, but first we need a vision – a systems level view – of where we need to be. We then need to design a workforce that would be fit for purpose for achieving that vision.

118 The VHMC should certainly have a key role in bringing together professional bodies and unions through a genuine process of engagement and consultation. The workforce is such a critical element of the mental health system and mental health reform that those bodies would need to be very effectively engaged as part of the planning and reform process.

119 When looking at the workforce of the future, large scale growth will be required. However, the workforce should also have an emphasis on team-based care, requiring collaboration and partnership between and within organisations. There also needs to be an emphasis on trauma-informed and culturally appropriate care.

120 The future workforce could ideally have a rotation of staff between service settings – such as between the hospital and the community – like in Trieste. There should also be a focus on integrating peer workers as part of the mainstream workforce.

121 As discussed above from paragraph 16, I also anticipate that the workforce of the future will have greater reliance on telehealth as a means of reaching people.

Growing the mental health workforce

122 In order to grow the workforce, we need to create momentum around the profession and the workforce in its broadest terms, and make it an attractive opportunity for people. Practically, that means engaging with students at senior high schools and targeting students who are going through the tertiary sector to form a pipeline for the future. We also could be providing incentives to train in mental health, whether through TAFE or through universities.

123 Significant growth is required in the mental health workforce – we are talking about creating thousands of new roles. People need to understand both the central importance of the mental health workforce, and the fact that growing this workforce will take time.

Changing the educational pathway

124 The educational pathway to the mental health workforce is conceptually fairly straightforward. You go to university, study psychology, medicine, social work or nursing and then enter the mental health profession. However, there is not a particularly strong pathway from school to university to the workforce, whether from the VET sector or the university sector.

125 We could improve this pathway by identifying and streaming people who want to have a career in mental health, and identifying a study and career path for those people. While we no longer have 'cadets' (people doing on the job training or apprenticeships) within the mental health workforce, we can integrate some of that thinking into how we attract and grow a domestic workforce.

126 We need to inspire people whilst they are young, and work with industry to place people, train them and give them the experience they need. Particularly if we provide incentives such as fee remission for people to do this training, they will be ready to start delivering services by the time they have their qualifications. The State Government has already identified the Certificate IV in Mental Health and the Certificate IV in Mental Health Peer Work as key qualifications that they are going to fund. Additional incentives will be needed, for example, for people to train in nursing and psychiatry.

127 We need to look at the workforce as a whole and target those particular groups of professions that we need in the short, medium and long term. There are of course very long lead times with the study of psychiatry and medicine, which need to be factored into this plan. In the short term, we need to encourage as many people as possible who have left the mental health workforce to come back into the profession or to 'jump ship' and come across from other professions. We can also incentivise retraining – for example, for nurses.

128 Professional development is also an important issue. For example, if service agreements included a requirement that service providers must release staff for their professional development, that would help people get the training and development that they need.

Recruitment

129 The Australian Defence Force is a good example of an effective public recruitment strategy. They advertise the benefits of the army for individuals and for the community. They go into schools and universities and engage with people at various stages of the lifecycle.

130 Another important recruitment strategy is to engage with other professional bodies and get them to be part of the push towards growing the workforce. This includes the medical colleges, the unions and allied health bodies such as the representative bodies for nurses, psychologists, and social workers. It is in all of these professions' best interests to grow the mental health workforce, including because it means potential new members of their professions.

131 We also have to look at providing incentives for people to work in regional Victoria. We may need to target particular needs in particular locations, and being able to come up with packages that meet those needs will be important. One suggestion is overseas recruitment programs, but in short term this will not be an option due to COVID-19.

Quality and safety

Facilitating continuous improvement of service delivery

132 The best way to facilitate continuous improvement of service delivery is through leadership and cultural change. We need to move from a mentality of crisis response toward a mentality of growth and development. I consider that the Collaborative Centre is a critical part of ensuring that high quality and safe services are delivered.

133 We also need to ensure that we have a unified approach to monitoring and oversight over the entire system. This will also ensure that there is proper accountability and continuous improvement embedded in the system. At present, significant parts of the system are not captured and reported to Parliament. The State and the Commonwealth are two smaller sub-systems that make up a bigger system. Much of what happens is not captured by, for example, Victoria's Mental Health Services Annual Report that is produced by the Department of Health and Human Services (**DHHS**) that is reported to Parliament and released to the public, because that report only covers State-funded services. In terms of Commonwealth services, some of these are captured through the Australian Institute of Health and Welfare (**AIHW**) Mental Health Services in Australia Report or through NDIA

reporting, but again there is no consolidation of reporting and oversight. I discuss the role of the VMHC in oversight and reporting above from paragraph 39.

134 We also need to look at what we actually measure and report. If you look at, for example, the DHHS annual report, there are many different metrics that may be of great interest to health economists and advocacy organisations like ours. However, there is not a lot in that report that is particularly helpful in terms of targets. The Outcomes Framework in Victoria's Mental Health Services Annual Report 2018-19, for example, includes a basic outcome of 'the gap in mental health and wellbeing for at-risk groups is reduced'.[9] While some population percentage indicators are reported, there are no targets or measures of progress.

135 Similarly, issues around whole of population mental health and wellbeing are not being considered. I hear repeatedly from clinical service directors that it is very difficult to get mental health onto the table in their discussions with senior executives because mental health has traditionally been a secondary issue to all of the other pressures that hospitals face.

136 We need to raise the importance of mental health in the hospital system. One way which has been quite successful in helping hospital executives to recognise this is by highlighting the links between mental health and other factors or outcomes which we know are high priorities for those services. For example, we know that hospital ED wait times are a major concern for hospital executives and government – when wait times are too long, the Minister starts calling hospital CEOs. Drawing on this, we could emphasise that if we do not do our jobs effectively in terms of looking after a person's mental health, we will have problems in the ED, which translates into longer wait times.

Commissioning

Strengths and limitations of regional mental health planning and commissioning

137 In theory, regional mental health planning and commissioning should result in services that are better tailored to regional needs. In practice, however, a lack of whole-of-system oversight coupled with under-resourcing has created fragmentation, inconsistency and gaps across the State. I think the pendulum has swung too far towards local commissioning and we need to swing it back towards more centralised oversight with regional input.

138 Having multiple organisations responsible for planning and commissioning of services creates fertile ground for fragmented service delivery, particularly in an environment where there are scarce funds. For example, there are 22 bodies commissioning

[9] Victorian Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2018-19* (October 2019) 78.

psychosocial support services: 6 PHNs and 16 Health Services. Each commissioning body commissions services differently and there is a lack of coordination and consistency across the State. If too many organisations at a local level are commissioning, then it becomes difficult for people to navigate services across the State. For example, an individual might move across the PHN or area mental health services boundary – which could even be just across the street or to a nearby town – and the service that they previously had access to is now not available. It becomes even more difficult when people search for services online. In the absence of a State-level digital concierge service, individuals have to wade through dozens of websites to work out what services might be available to them.

139 The current model of commissioning is also inefficient, because one service provider may have multiple different contracts with different commissioning bodies for the delivery of the same service in different regions. That increases overheads and reduces the actual money that is available for service delivery.

140 We need to aim for a consistent and standard service available to all Victorians which can be monitored and evaluated. To achieve consistency, commissioning should be done jointly or in collaboration between PHNs and DHHS, in consultation with local communities. This still allows for some variation in service delivery on a local level: services would be delivered in a specific way for and by the ATSI population, for example. There is, for example, no reason why we could not have a state-wide approach to the delivery of psychosocial support services which forms part of the State's mental health plan and is then applied at a local level.

141 The Productivity Commission Inquiry is also very much grappling with this issue. Their preferred model is to effectively bring together all of the various funding sources into a regional commissioning body or multiple regional commissioning bodies. MHV's view is that if we separate out commissioning of mental health services, we run the risk of contributing to the fragmentation and silos that separate mental health from other areas such as physical health, housing and homelessness. We would prefer not to go down that path.

Innovation

Enabling and incentivising the development and implementation of new and innovative service models

142 If you have a vision, proper resourcing and proper oversight and evaluation, then you can embed new and innovative service models. The Victorian Collaborative Centre for Mental Health and Wellbeing, recommended by the Royal Commission, will also play a role in creating the impetus for collaboration and innovation.

143 A better resourced system not operating in crisis mode would allow for greater innovation. That said, the sector and workforce are good at doing things differently with their tight resources: for example, even with tight resources, we are seeing changes occur rapidly in response to COVID-19.

144 We also need to recognise and reward innovation. This does not necessarily mean financial rewards for organisations and individuals, but rather initiatives such as state-based or national mental health service awards to recognise innovative practice. You cannot force people to innovate: it is better to bring them along by recognising good practice and modelling it.

Employment

Key challenges for accessing employment

145 People who experience mental illness, and their carers, experience high levels of unemployment. There are a number of key challenges to helping these people access and maintain employment, including:

(a) a lack of services to keep people safe, well and securely housed;

(b) the nature of mental illness, which can be episodic;

(c) the stigma and self-stigma associated with mental illness;

(d) the fact that people with mental health issues also often have poorer early and ongoing education outcomes, for example higher school non-completions;

(e) employers and managers having capability deficits as to how to manage support;

(f) poor coordination of services across the mental health sector and employment, education and training sectors; and

(g) limited support services available, such as Individual Placement and Support programs (**IPS**).

Individual Placement and Support programs (IPS)

146 In MHV's submission, we set out the evidence behind IPS. IPS has already been demonstrated to be effective for adults and is ready to be implemented, with a systematic review and meta-analysis of international evidence showing it is more than twice as likely to lead to competitive employment when compared with traditional vocational rehabilitation for people with severe mental illness.[10] Whereas usually no more than 20%

[10] Modini M et al., 2016, Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence, in The British Journal of Psychiatry, Volume 209, Issue 1, pp. 14–22.

of people with severe mental illness typically return to work without support, IPS can yield rates of up to 60% or more.[11]

147 A good example of IPS recognised by the Organisation for Economic Co-operation and Development (**OECD**) is the trial funded by the Commonwealth Department of Social Services tailored to adolescents and young adults, which finishes in June 2021. The trial integrates psychology, social work, GPs and vocational support with close collaboration with public employment services embedded into daily practice.[12]

148 Returning to work can be a time of stress and renewed mental health difficulties. However, co-locating IPS employment specialists with a community mental health team, so that a range of employment supports can be coordinated with treatment and care plans, can help reduce this stress. Further, help from mental health team members can be sought as needed to help people face and overcome the new challenges that can be encountered in any workplace.

149 Policy makers should consider three factors that the OECD consider critical to success when evaluating IPS:[13]

(a) the alignment of policy objectives and financial incentives (welfare current set up can de-incentivise);

(b) rigorous implementation; and

(c) on-going evaluation.

Prevention

The extent to which mental illness can be prevented

150 There needs to be tailored and holistic treatment options for people who are mentally unwell, but also a focus on preventing people from becoming unwell in the first place, or preventing their condition from becoming more severe so they remain safe, well and productive in the community. It is widely accepted that the more severe the illness or presentation, the more restrictive, intensive and expensive the approaches usually are.

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[11] Harvey SB, Modini M, Christensen H and Glozier N, 2013, 'Severe mental illness and work: What can we do to maximise the employment opportunities for individuals
with psychosis? ANZJP Perspectives' in Australian & New Zealand Journal of Psychiatry, Volume 47, Issue 5, pp. 421-424.

[12] See further Department of Social Services, Australian Government, 'Individual Placement and Support (IPS) Trial' <https://www.dss.gov.au/mental-health-programs-services/individual-placement-and-support-ips-trial> [accessed 2 June 2020].

[13] OECD (2015) *Mental Health and Work: Policy Framework*, OECD Publishing, Paris, 12.

151 There is a considerable evidence body to show that many conditions can be prevented from occurring.[14] There is also good evidence to show that a focus on preventative methods is cost-effective.[15]

152 Mental health should be viewed holistically. Mental health is not a set of discrete conditions but a broad concept relating to social and emotional wellbeing. There are many risk factors for mental health problems and mental illness and some risk factors may act as immediate precursors to mental health problems and mental illness. These include:

(a) bereavement;

(b) relationship breakdown;

(c) removal from family and social supports;

(d) being in a carer role;

(e) unemployment and other major life events;

(f) a biological predisposition; and

(g) adverse childhood events, including deprivation and abuse.

153 Some of the risk factors listed above are linked to the individual, such as drug and alcohol use and physical health problems. Others occur at a community level and include social exclusion, discrimination and bullying. Certain life stages render individuals particularly vulnerable (e.g. childhood, adolescence and old age). Further, some population groups, such as Aboriginal and Torres Strait Islander peoples, and people who are homeless, unemployed, newly-arrived or refugees, are recognised as being at heightened risk of mental illness and should therefore receive particular attention.

154 There is no one approach to preventing any particular mental illness. Rather, a focus on improving mental wellbeing generally will reduce the likelihood that a person's mental health will slide further along the continuum towards a diagnosable condition.

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[14] Ebert, D. D. & Cuijpers, P, 2018, *It is time to invest in the prevention of depression*, in JAMA Network Open, Volume 1, Issue 2. doi:10.1001/jamanetworkopen.2018.0335; Mendelson, T., & Eaton, W. W, 2018, *Recent advances in the prevention of mental disorders*, in Social Psychiatry and Psychiatric Epidemiology, Volume 53, Issue 4, pp. 325-339; Arango, C., Diaz-Caneja, C. M., McGorry, P. D., Rapoport, J., Sommer, I. E., Vorstman, J. A. and Carpenter, W., 2018, *Preventive strategies for mental health* in Lancet Psychiatry, Volume 5, Issue 7, pp 591–604.

[15] McDaid, D., & Park, A, 2011, *Investing in mental health and well-being: findings from the DataPrev project*, Health Promotion International, 26(Suppl_1), i108-i139; Knapp, M., McDaid, D., & Parsonage, M., 2011, *Mental health promotion and mental illness prevention: The economic case* in Journal of Poverty & Social Justice, Volume 19, Issue 3, pp 297-299; Mihalopoulos, C., & Chatterton, M, (2015), *Economic evaluations of interventions designed to prevent mental disorders: a systematic review* in Early Intervention in Psychiatry, Volume 9, Issue 2, pp. 85-92; Mihalopoulos, C., Vos, T., Pirkis, J., & Carter, R., 2011, *The economic analysis of prevention in mental health programs* in Annual Review of Clinical Psychology, Volume 7, pp 169-201; Mihalopoulos, C., Vos, T., Rapee, R.M., Pirkis, J., Chatterton, M.L., Lee, Y., & Carter, R, 2015, *The population cost-effectiveness of a parenting intervention designed to prevent anxiety disorders in children* in Journal of Child Psychology and Psychiatry, volume 56, issue 9, pp 1026–1033.

155 Some mental illness can be prevented, or its severity reduced, by enhancing protective factors and focussing on population groups where known risk factors exist. This may prevent considerable occurrences of depression and anxiety, for example.

156 For people with severe mental illness, we can work with them to intervene early and prevent individuals from getting so unwell that they need to present to hospital, for example. That will require an appropriate balance of medical and community support services and whatever else is required to keep people safe and happy in the community.

Effective approaches to prevent mental illness or prevent its reoccurrence

157 Ultimately, success requires a combination of appropriately timed and targeted evidence-based interventions and strong coordination. This should be based on the principles discussed below.

158 **Across the lifespan:** Prevention initiatives are needed across the whole lifespan. However, primary prevention activities need to occur before the first onset of a condition and should therefore be maximised in the first few decades of life, including the perinatal, childhood, adolescent and young adult periods.

159 **Focus on risk and protective factors:** Success depends on addressing risk factors and strengthening protective factors that influence the onset of mental health and related conditions. Approaches should take account of the variations and uneven distribution of risk and protective factors along dimensions such as gender, sexual orientation, geography, socioeconomic status and cultural identity.

160 **Focus on protective and risk factors in childhood:** Adverse Childhood Experiences (ACEs) are varied, but the most impactful include child maltreatment (physical, emotional and/or sexual abuse or neglect), exposure to family violence and having a parent with a severe mental illness, alcohol or substance use disorder or history of incarceration. Research shows that individuals who are exposed to these experiences while growing up are at increased risk of developing a mental health and/or physical health condition, including chronic disease. Some experts argue that the prevention of ACEs needs to become a core focus of efforts to prevent mental health conditions.

161 **Multiple settings:** Risk and protective factors are distributed across multiple social environments and so prevention initiatives are needed across a range of health and non-health settings including:

(a) online;

(b) the home;

(c) education settings;

(d) workplaces;

(e) sports, arts and other recreational associations;

(f) health sector services, including community services, and perinatal services;

(g) family violence services;

(h) aged care facilities;

(i) housing;

(j) legal services and the justice system; and

(k) local communities.

162 **Targeted approaches**: Strategies need to be targeted at the general population as well as clinical populations. Initiatives focused on people with subthreshold symptoms, to prevent their progression into a 'full-blown' condition, also have a place. Furthermore, risk and protective factors vary across communities and interventions must be tailored to ensure that people and communities receive appropriately targeted assistance.

163 **A focus on the relationship between physical and mental health:** Not only do mental and physical health conditions share a number of major risk factors in common, but research shows a strong bidirectional association between the two. In others words, they are both independent risk factors for each other. Reducing the incidence of mental health conditions cannot be achieved without targeted gains in physical health.

Population-level approach to preventing mental illness

164 As discussed above, it is known which groups in the community are vulnerable to mental illness and we know the key principles for prevention to be effective. However, ensuring that prevention approaches are targeted and present across all settings is not enough; there needs to be an overarching plan and a governing body to oversee the planning, roll-out, implementation and monitoring and evaluation.

165 The governing body best placed to implement this is the VMHC in conjunction with the NMHC. Having the two bodies working together would help to bring a whole of population approach. At a state level, the VMHC would have a key role in bringing together organisations like VicHealth, Prevention United, Worksafe Victoria and other organisations to push prevention as a priority.

166 The VMHC and NMHC could also coordinate and focus public campaigns which could be fronted and 'owned' by our political leaders. Such public campaigns will help encourage people to think about mental health. Whilst we are seeing increased public awareness and acceptance over the past ten years (and particularly over the past few months), we need public awareness campaigns which tell people where to go and what to do and give

them the skills and support that they need to access services or to assist others. The word 'resilience' gets used a lot but I do think we do need to look at how we equip the whole population to manage their mental health and wellbeing better.

167 The evidence-based policy plan that is designed needs to be embedded across all levels of government – federal, state and local. This plan needs an adequate level of detail to ensure that it is actionable and accountable and includes priority targets for intervention. Specifically, the plan should link to the Fifth National Mental Health and Suicide Prevention Plan and the National Framework on Chronic Disease. It is also critical that all future National Mental Health Plans include prevention as a priority issue so that prevention becomes a central policy pillar.

168 Much of the harm reduction that has been achieved with respect to smoking, harmful alcohol and substance use, and road trauma, has been achieved through data and evidence-backed changes to legislation and regulation. Public policy changes have been less systematically implemented for the prevention of mental health conditions and further consideration is needed to clarify what particular policy initiatives are important to pursue.

169 An example of a whole of population approach is the Scottish Government mandating that all frontline workers undertake mental health first aid training. This means that mental health first aid is incorporated into organisations as on the same level with parity to physical first aid. We need to elevate mental health first aid to the same point through reinforcing it at a state level and within business and organisations.

Determinants of mental health that public policy should consider

170 There are a number of determinants which influence mental health. The Victorian and Commonwealth Governments should focus on addressing each determinant, including:

(a) economic disadvantage;

(b) adverse childhood experiences;

(c) unemployment;

(d) homelessness;

(e) family violence;

(f) contact with the criminal justice system; and

(g) discrimination.

171 One factor which requires particular consideration is housing (which is a key success factor in Trieste, as discussed above at paragraph 35). This is because the rate of mental illness among people experiencing housing crisis is significantly higher than that of the

general population. In 2017–18, 31% of people presenting to Specialist Homelessness Services had a current mental health issue[16]. Almost two thirds (64%) were returning clients.[17] Further, without adequate and long-term shelter, other measures to support a person's mental health or prevent a condition from worsening are likely to be largely ineffective.

172 In order to address this determinant, the government should implement 'Housing First' models, which prescribe safe and permanent housing as the first priority for people experiencing homelessness. This is to be followed by multidisciplinary support to address other complex needs such as mental illness or drug and alcohol issues. This model shows impressive outcomes for tenants (particularly those with long histories of housing insecurity)[18] and efficient resource allocation for governments[19].

173 Not all housing options are suitable for all people. Increased investment and effort are required to supply a range of housing options, including public and social housing, specialist supported accommodation for people with mental illness, transition housing, private rental, ownership and other private accommodation such as rooming houses and supported residential services. Each of these require targeted policies to improve system capacity.

174 To ensure that people with mental illness can access housing options which work for them, governance bodies will need to lead the integration of the housing and mental health sectors. These bodies will need to work together to develop and implement a housing strategy which makes particular reference to people with mental illness. The strategy should also address the disparity of access to housing options for people living in rural or regional areas.

The role of communities in influencing these determinants

175 Communities have a critical role in response to the issues discussed above. There is a need for targeted approaches to issues such as unemployment and housing. Ultimately, the success of these approaches will turn on how they are delivered within a community setting. We should be equipping local community leaders and individuals to be able to assist the process. As we have seen with the bushfire response, recovery generally

[16] Australian Institute Health Welfare (2018) Couch surfers: a profile of Specialist Homelessness Services clients, Cat. no. HOU 298, Canberra.
[17] Ibid.
[18] Holmes, A., Carlisle, T., Vale, Z., Hatvani, G., Heagney, C., & Jones, S., 2017, *Housing First: permanent supported accommodation for people with psychosis who have experienced chronic homelessness*, in Australian Psychiatry, Volume 25, Issue 1, pp. 56-59.
[19] Ly, A. & Latimer, E., 2015, *Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature*, in The Canadian Journal of Psychiatry, Volume 60, Issue 11, pp. 475-487.

comes down to the will and force of local communities and individuals who are willing to assist, and who in fact step up.

Jurisdictions and parallel systems that have embedded innovation into a prevention or promotion program

176 To my knowledge, no jurisdiction in Australia, or globally, has a clearly articulated framework for promoting mental wellbeing, preventing mental disorders and evidence of wide-scale resourcing and implementation of initiatives within that framework.

177 The UK and Canada are probably the most advanced jurisdictions in terms of setting a broad-based promotion and prevention agenda. However, they still have a very ad-hoc approach to implementation. Domestically, Western Australia is probably the most advanced jurisdiction in terms of outlining a promotion and prevention agenda, but again the range of activities on offer there is limited.

178 Of the various parallel systems to mental health, we have the most to learn from the health sector and, in particular, from the prevention of infections, cardiovascular disease and cancers. The other area to draw from is the prevention of AOD issues. While there are examples of primary prevention initiatives in other areas, such as child protection or domestic violence, it is difficult to find scalable and comprehensive approaches to prevention outside of health and AOD.

179 When looking at individual programs, there are numerous evidence based approaches to promoting mental wellbeing and preventing mental disorders. Many promotion initiatives draw heavily on positive psychology interventions (**PPIs**) which have a strong evidence base. Some programs focus on packaging a variety of PPIs such as public awareness initiatives like Act Belong Commit (from Curtin University in Western Australia) and Five Ways to Wellbeing (in the UK and also in Australia in some locations).

180 The field is more developed when it comes to the *primary prevention* of mental disorders. Examples include programs that target pregnant women through antenatal services, children and young people through schools, and adults through workplace initiatives.

181 The two groups of interventions with the strongest evidence for primary prevention include parenting programs and school-based social and emotional learning (**SEL**) and resilience programs. Effective parenting programs provide practical support, promote secure attachment, and give parents an opportunity to learn and practice skills including effective communication, emotion coaching, boundary setting, conflict resolution, and other positive parenting skills. The evidence around workplace-based prevention programs is also steadily growing.

182 Effective prevention programs for young people teach the social and emotional skills that contribute to resilience. Effective prevention programs for adults teach self-care skills derived from health, clinical and positive psychology.[20]

Key factors relevant to mental health promotion and prevention policy reform

183 In my opinion, we need to stress the following factors when talking about promotion and prevention policy reform:

(a) promotion and prevention require a 'public health' response, rather than a mental healthcare response. Public health responses target the underlying 'causes' (i.e. risk and/or protective factors), are geared towards groups and whole communities rather than individuals (i.e. high-reach/scalable) and generally occur in non-mental healthcare settings (e.g. the home, education settings, workplaces, etc);

(b) individual behaviour change programs are not enough – they need to be coupled with public awareness campaigns, and mentally healthy public policies directed at the social determinants of mental health;

(c) picking 'winners' and funding one or two evidence-based programs is not enough. We need to put in place a comprehensive approach that combines campaigns, programs and policies targeted to as many risk and protective factors as possible. This will require us to build a 'public health' system in mental health to complement our mental healthcare system. This component needs its own specific governance arrangements, interventions, workforce, data and funding; and

(d) prevention is not the same as early intervention. Prevention is about stopping a condition from ever occurring, whereas early intervention is about the early detection and treatment of first-episode or existing mental disorders.

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[20] See, e.g. https://community.mydigitalhealth.org.au/resource-list/.