Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ELIZABETH CROWTHER

I, Elizabeth Crowther, CEO of Wellways Australia Limited (**Wellways**), 276 Heidelberg Road, Fairfield, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Relevant background and experience

2 I have over 24 years' experience working in the community mental health sector. I have always had a deep interest in people living their lives effectively in the community.

3 Since 1996, I have been the CEO of Wellways.

4 From 1987 to 1995, I was the Director of Nursing at Royal Park Hospital, where I oversaw the process of deinstitutionalisation at that hospital.

5 From 1971 to 1977, I worked as a Clinician and Nurse Educator at Larundel Hospital.

6 From 1969 to 1970 I worked as a registered nurse in various roles; for example, Fairfield Infectious Disease Hospital, Agency Nursing, Aged Care in Melbourne.

7 I hold the following qualifications and appointments:

(a) General Nurse (1968).

(b) Qualified Psychiatric Nurse (1970).

(c) Diploma of Nursing Education (1975).

(d) Graduate Diploma in Health Administration (1989).

(e) Bachelor of Applied Science (psychiatric nursing) (1992).

(f) Certificate IV in Assessment and Workplace Training (2002).

(g) Victorian Women's Honour Roll (2012).

(h) Senior, Fellow School of Nursing: Melbourne University (current).

Current role and responsibilities

8 As CEO of Wellways, I look after its overall business and growth. I ensure that it is effective, financially able and that it delivers services of quality to people in the

community. Wellways has grown from an organisation with an annual turnover of $1million in 1996 to this year's budget of $114 million.

What is Wellways? What services does it provide and in what activities does it engage?

9 Wellways is a leading not-for-profit mental health and disability support organisation. It operates from Hobart to Townsville.

10 Wellways works with individuals, of all ages, experiencing disabilities or challenges to their social and emotional wellbeing. Wellways works in partnership with people and their families to identify their own needs and goals, and supports them to attain a great life in the community. Wellways provides an individually designed support process for each individual it helps. This can include creating a home, securing a job and building meaningful relationships. Wellways does not provide case management services; it supports individuals to take control of their own lives.

11 Since its foundation in 1978, advocacy has been central to the work of Wellways. It advocates to improve the services, information and support available to people with mental health issues, their carers, families and communities. Wellways advocates to improve the quality of the services and supports available. I apply the principle – "if it is not good enough for my family, it is not good enough for others".

12 In Victoria, Wellways' services include:

(a) NDIS service provider;

(b) health and wellbeing services;

(c) helping people being part of a community;

(d) helping people to maintain a home;

(e) helping people to find employment and educational opportunities;

(f) helping to coordinate support services;

(g) helping to provide support for families, friends and carers;

(h) operating the national Wellways Helpline;

(i) operating Prevention and Recovery Centres (**PARCs**) and

(j) Advocacy.

Examples of services Wellways provides

13 The types of services Wellways provides is best demonstrated by example. **Attached to this statement and marked "EC-1"** is a de-identified case study which is an example of the types of services Wellways provides.

14 Further examples of the programs Wellways offers are as follows.

Doorway

15 Doorway is a program that Wellways runs in collaboration with a number of clinical services in Victoria; for example, St Vincent's Hospital. Doorway supports people experiencing mental health issues who are homeless, or at risk of homelessness, in securing and sustaining a home within the private rental market.

16 Wellways advocates for clients to secure the rental home, and undertakes to cover any damage of the property (there is very rarely, if ever, any damage). Wellways meets with the clients weekly and as needed to help them ensure the rent and bills are paid, they are emotionally stable, connected in their local communities and are supported by their mental health plans.

17 Wellways helps the client develop all the life skills that are needed to live independently – for example, ensuring the house is clean and tidy, and there is food in the fridge, a budget established to support need, a relationship established with real estate companies to establish a positive rental history and a plan for the future.

18 Wellways also builds opportunities to work and to reconnect with family.

19 The program has been very successful. Of the first cohort of 50 people in 2011, 80% of those people, who were previously homeless, are living independently.

Employment Personal Helpers and Mentors Service

20 The Employment Personal Helpers and Mentors Service draws on the experience of peer workers to support people with mental health issues to access and maintain satisfying employment training or education.

Partners in Recovery

21 The Partners in Recovery program coordinates supports for people with severe mental health issues and complex needs. The program works with the individual, their friends and their family to ensure they get the support they need.

Personal Helpers and Mentors Service

22 The Personal Helpers and Mentors Service draws on the expertise of peer workers to support people with mental health issues in building confidence, overcoming social isolation and increasing community connections.

Prevention and Recovery Care

23 Wellways is also subcontracted by the Victorian Government through local hospital networks. We run six PARC services across Victoria in partnership with specialist clinical mental health services. We also run two services in the Australian Capital Territory, which are directly contracted through government.

24 PARC services are a community-based, short-stay residential program offering a supported and therapeutic living environment to people post-hospital admission to assist their recovery, or to prevent a hospital admission when a person's mental health is deteriorating. There are a number of models. Each hospital chooses its own model of care.

25 The six PARC services in Victoria are located in Bairnsdale, Mildura, Shepparton, South Yarra, North Fitzroy and Frankston. As stated above, there are also two PARC services in the Australian Capital Territory.

26 Wellways runs the rehabilitation and housing component of the PARC services.

27 PARC services give people focussed emotional input and support so that they don't have to go into hospital, or can leave hospital earlier. The difficulty is when they leave the PARC there are too often no linking programs. The development of linking programs is determined by various commissioning bodies and their priorities, access policies and availability. The relevant area mental health service may or may not have a continued mental health treatment role; however, the community support is plagued by the issues above. For example, many individuals experience a drug and alcohol issue and have not agreed to treatment before departure, or have tenuous unresolved housing issues.

Where does Wellways fit within the mental health system?

28 Wellways is not a clinical service. It is a support service. We support people and their families where the person's disability or illness is compromising their life, or where they are not able to engage with traditional social structures (for example, housing, employment, education, community). Wellways' work focuses on relationships – for example, where a person is experiencing social isolation because of their illness.

29 We believe that services must address psychosocial disability in a community setting – both prior to the emergence of illness, and in between episodes for those experiencing psychosocial disability. Our goal must be to reduce disability as early as possible. Long term disability means people may never, even as symptoms abate, lift out of poverty and exclusion.

Who receives Wellways' services?

30 Wellways works with individuals of all ages, including those experiencing disabilities or challenges to their social and emotional wellbeing. Wellways also provides support services to the family and friends of those struggling with mental illness.

Are there any criteria for people affected by mental illness to access Wellways' services?

31 Wellways prioritises people who are really unwell and in need of support services. Wellways aims to support those who struggle to look after themselves. While we do not have entry criteria, the different contracts which govern the particular tendered services have their own criteria or key performance indicators.

Does Wellways assist people affected by mental illness of all degrees of severity and complexity? If not, what group does Wellways serve?

32 Wellways' priority is people with severe and chronic mental illness. Our mission is to work with society's most disadvantaged. Therefore, we mainly support people who suffer from psychotic illnesses, as these people tend to have multiple and complex needs. Roughly 45% of our clients have a diagnosis of schizophrenia.

33 However, anyone with a mental illness can come to Wellways for support. Wellways supports people with all types of acute mental illness, at any stage of their illness.

Do Wellways' clients have to come from any particular geographic location?

34 Wellways supports people in the geographic areas for which we have services. As Wellways' support services are relationship-based we cannot support people who are not based near our services. The nature and type of service available depends on where the individual lives.

35 In Victoria, we work in all regions with the exception of the Northern Mallee, Southern Wimmera and northern Ovens Murray.

Does Wellways provide any clinical services? If not, what kinds of providers meet the clinical mental health needs of Wellways' clients?

36 Wellways is not a clinical service, but Wellways works in collaboration with clinical services. Wellways' partners include clinicians, GPs, hospitals, community health organisations, government and local businesses.

What other parts of the mental health system are your clients likely to use (or want to use)?

37 Generally, Wellways' clients are likely to be seeing a GP regarding their mental health and also using their local area mental health service. The area mental health services arrange themselves differently. In some areas there are combined Crisis Assessment and Treatment Teams (**CATT**) and Mobile Support Teams (**MST**). In other areas, there are integrated teams, continuing care teams, programs for the homeless, or the multitude of designs that fit the local area. We link to other community providers and will offer 'warm' referrals. We have contact with youth services for specific programs and homeless agencies.

38 Unfortunately, many people have limited family and friend networks, and many of these individuals end up in the forensic system.

How are clients introduced to Wellways?

39 Clients are introduced to Wellways in various ways. For example, clients can be introduced by their parents, by the area mental health services, and via various community organisations such as the Brotherhood of St Laurence, schools and the general community. Many people who come to Wellways are not supported by area mental health services. Some are with GPs or private psychiatrists, and others have dropped out of services all together.

40 Sometimes how the person is introduced to Wellways depends on the program. For example, people are introduced to the Doorway program via St Vincent's Hospital. When a person is homeless or at risk of homelessness, and presents at St Vincent's with a mental illness related issue, St Vincent's contacts Wellways and asks if Wellways can meet with the individual to see if they would like to participate in the program.

41 People can also call the Wellways Helpline to help them.

Does Wellways have partnerships or links to clinical services? If so, what are they are how do they work?

42 Wellways has strong links to clinical services. For instance, when a person is becoming acutely ill we connect them with an area mental health service. We will help to organise for the person to see a GP and to get a referral to a psychiatrist. We can also organise for the CATT or MST to attend and support the person, if needed.

43 As mentioned above, Wellways operates six PARC services in Victoria in partnership with specialist clinical mental health services.

44 Some of our programs involve direct partnerships with clinical services. For example, the Doorways program is run in collaboration with St Vincent's Hospital.

How is Wellways funded?

45 Wellways is a not-for-profit organisation that receives funding from the Commonwealth Government, the state Government (Tasmania) and local governments. Wellways also receives short-term funding through the National Disability Insurance Scheme and Primary Health Networks.

What is Wellways' model for "Community Inclusion" and what practical steps are required to implement it?

46 Wellways focuses on community inclusion – a commitment to ensuring all the people we serve have opportunities to fully participate in the community, without stigma and discrimination.

47 One of the most consistent themes repeatedly fed back to Government is that care for the most vulnerable people, those with severe and persistent mental health issues, is not adequately integrated or coordinated. As a consequence, people with complex needs often fall through the resulting gaps.

48 Community managed mental health services are a vital part of the mental health system. They provide care in a community setting, to people with severe mental health issues and psychosocial disabilities. Community mental health services provide early intervention when people become unwell, and also support people to return to their community from more acute settings like hospital. Community support is a cost-effective intervention because it can help to reduce costly hospitalisations and time away from work.

49 Community-based collaborative care models build a team of professionals around a person experiencing mental health issues, including GPs, psychiatrists, support workers and allied health, housing, education and employment agencies. There is strong evidence that this type of model of care improves health. Economic modelling indicates that this intervention can deliver a return on investment of $3 for $1 invested.[1]

50 From our perspective, community inclusion has two essential components: first, that all individuals have an opportunity to fully participate in the community; and second, that communities actively seek out and welcome the participation of everyone, valuing each individual's uniqueness and abilities. Wellways' Inclusive Communities Initiative would provide a digital link-up between services offers, have in place a funded mechanism for

[1] Mental Health Australia (MHA) and KPMG 2018. *Investing to save: The economic benefits of investment in mental health reform: Final Report*, Canberra, May 2018.

services to talk one with the other and assisted pathways for individuals to get the services that they need. This may include helplines, coaching services etc. **Attached to this statement and marked "EC-2"** is a document produced by Wellways which outlines Wellways' Inclusive Communities initiative to provide a new digital mental health gateway and coordinated support for adults with severe and persistent mental health issues.

51 We believe that some of the practical steps required to implement community inclusion are, first, reorienting service providers to mainstream health system opportunities, and second, addressing barriers that currently in the community.

52 Community inclusion has been overlooked in the past, to the detriment of those with psychosocial disabilities. For instance, there is strong evidence that, despite the downsizing of large mental hospitals, those individuals affected by mental health conditions remain substantially segregated from the mainstream. For example, housing is often clustered in poorer communities where less adequate housing, limited access to human services and other neighbourhood resources, and the problems of crime, lead to diminished opportunities for participation.

53 Individuals need to be given increased opportunities for self-determination. While there are no self-determination interventions per se, there are a number of current and emerging interventions where self-determination plays a role. For example, the Wellness Recovery Action Plan is rooted in the principle of self-determination and involves an individual, often with support from a peer or group of peers, identifying issues that are intrusive or troubling and implementing strategies for coping with or overcoming them, along with a plan for increasing empowerment, quality of life, and the achievement of their own life goals and dreams.

54 There are a number of types of support for persons with psychiatric disabilities which aim to foster community inclusion. Individuals with psychiatric disabilities may experience social, problem-solving, and cognitive impairments that may interfere with the development of a positive person-environment fit within many environments. For example, building natural supports that the person can control, and creating housing options. Both of these measures, when deployed through the community, will help to support the creation and achievement of individual goals, which will result in sustainable community outcomes.

55 An Inclusive Communities Model (**ICM**) of care should be established to provide coordinated support for people with severe and persistent mental health issues, across Australia to improve access to local and targeted services.

56 The ICM aims to better support people with severe and persistent mental health issues, and their carers and families. ICM works by facilitating collaboration, coordination and integration amongst services and supports from relevant sectors.

57 The objective of ICM is to improve the system response to, and outcomes for, people with severe and persistent mental health issues by:

(a) facilitating services to deliver 'wrap around' care individually tailored to the person's needs;

(b) strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the ICM target group; and

(c) promoting a community-based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental health issues.

58 A focus on community inclusion also requires a consideration of the whole family. It challenges services to provide support that enables the development of mutually supportive relationships within families. It also provides pathways for families and friends to engage in their own journey of recovery.

59 Something akin to GENIE could be implemented in Australia to facilitate community inclusion. GENIE is a website that connects people with long-term conditions to local health and wellbeing activities, and has been developed to help people visualise and think about the important relationships around them (family members, friends, healthcare professionals and local groups).

60 The GENIE tool guides users through four stages: firstly, to map and reflect on their social network; second, it uses a short questionnaire to identify enjoyable activities; third, the location of each activity is then displayed on a map together with contact details; and fourth, relevant online resources are explored.

In your experience, in relation to the needs of people affected by mental illness for clinical treatment and psycho-social services (whether provided by NGO's or others):

What is the scale of unmet need in Victoria?

61 In the 1990s, people who lived in institutions generally had severe and chronic mental illnesses. At that time, we, the system architects, did not have experience or knowledge of what someone with those conditions needed to successfully live in the community. The system was designed through a health lens. Mental illness is not the whole part of someone's life. We need to perceive people with mental illness through a community and inclusive lens.

62 The current model presumes that the only determinant of mental illness is health. Mental illness is a consequence of related factors, including: early childhood trauma, and social factors like housing, isolation, employment and community. It follows that good system design should address these factors; for example like "Well together" addresses family support.

63 Victoria has slipped from having one of the best-funded mental health systems to one of the worst. People with severe and chronic mental illnesses who are living in the community – the "missing middle" – have suffered the most. There has been a consistent policy over time of investing in the pointy end, or crisis end, but not services and support for people with severe and chronic mental illnesses who are living in the community. That cohort has consistently missed out.

64 In my opinion, part of the difficulty is that systems are designed to look at streams – housing, employment, health – and this is underpinned by straight political tensions about each department coming in on budget. These streams do not reflect the needs of the individual. For example, the Doorway program struggled to get off the ground because the Department of Health said it belonged to the Department of Housing, and the Department of Housing said it belonged to the Department of Health. Ultimately, it was pure chance the program was supported.

65 In addition, there have been significant changes in relation to the services provided with the introduction of the NDIS (which I refer to below).

66 There is very limited funding directed to identifying people when they are getting unwell; the majority of the funding is directed to the pointy end, when people are acutely unwell. This needs to be turned around. There is a need to look at earlier social interventions. This will provide better support to the cohort living in the community and alleviate the pressure on the pointy end.

If there is unmet need, what needs are the most critical?

67 In my view, support for housing and building relationships is the most critical need. The community has become segmented. The capacity to go to an event and meet someone and form relationships is diminishing. We seem to be looking at an online future. While this has many advantages, the lack of face to face community contact means people are increasingly socially isolated, and lacking fundamental relationships.

What do you think are the key drivers of unmet need?

68 The key driver of unmet need is the underfunding of programs that identify people when they are getting unwell (early intervention programs) and programs that intervene at all stages of health and illness. Once people become unwell there is a lack of support and

services until they reach a stage of acute need. However, the demand for services at the acute end of the system is far greater than the supply. Consequently, people are unable to get the help they need early in the community, or at the acute end of the system. The current funded services are inadequate to intervene with effective community supports where symptoms are escalating, and where social interventions may be an effective alternative.

69 I believe that the lack of investment in community support services is demonstrative of funding not being given to a broad scope of needs. In the recent survey of 100 users common response were, a bad experience of clinical mental health and a system needing to have more thinking about alternatives; a requirement for there to be community response between the GP and the hospital level; more housing options; more regional and rural services distributed across community.

Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services?

70 Yes, the "missing middle" in society needs to be addressed. We believe that the missing middle can be helped through funding being given to the services that do non-stigmatising community connection work. For instance, if someone struggling with mental illness is having financial problems, it would help them to be introduced to a financial planner who can help them with those problems. Wellways provides support to deal with the fundamental issue that is holding them back. Our aim is to coach people rather than to put them in a bed for more than $1,000 per day. There needs to be a focus on adults who have a severe and persistent mental health issues that require a response from multiple agencies.

71 These individuals have persistent symptoms and significant functional impairment, and as a result, they may have become disconnected from social or family support networks. This can lead to extensive reliance on multiple health and community services for assistance, to maintain their lives within community-based settings and outside of institutional care. They may have comorbid substance use or physical health issues or both. They are likely to experience difficulties maintaining stable accommodation, and performing the basic requirements of everyday life. It is reported that these individuals often fall through the system gaps, and they require more intensive support to effectively address their needs.

72 This cohort are generally in their mid-twenties and above, this is reflective of the typical development of severe and persistent mental health issues.

73 There are a range of Government sponsored programs, such as the Early Psychosis Prevention and Intervention Centre (**EPPIC**) program and headspace. These programs are aimed at early intervention for young people, who may be developing a mental illness. The programs aim to reduce the risk of long-term disability. However, an initiative with a focus on supporting adults who have severe and persistent mental health issues is required.

What kind of impact does unmet need have on people affected by mental illness?

74 Late intervention results in people becoming more unwell. This often results in losing housing, family relationships, increased presentation in emergency departments, longer stays in hospital, discharge from hospital before the person is ready, adverse community reaction, increased stigma, and jail.

Specifically in relation to access to the kinds of services that Wellways provides (whether provided by NGO's or others) is supply keeping up with demand? What gaps have you observed?

75 My view is that supply is not keeping up with demand for Wellways' services. There are not enough housing supports to have real community inclusion. This also impacts upon the ability to find paid employment.

Are there barriers to people affected by mental health, accessing psycho-social services? If so, what are they?

76 In my view, the main barrier to people accessing psychosocial services is funding, given the number of people that require these services.

77 Wellways and MIND are in the middle of a consultation with consumers and carers across Victoria. We have consulted with 100 people in different groups, but have not yet had time to thoroughly review the emergent themes. However, some of the key themes we have identified thus far are: services closing down, no access to the NDIS, hit and miss access to services, services not meeting personal needs, bureaucratic maze, integration of services, continuity of care, family inclusiveness, cultural sensitivity and language.

Are opportunities being missed to help people when they first need treatment and support? If so, how?

78 Opportunities are being missed to help people when they first need it because the system is so fragmented. It seems to me that GPs are trained to focus on health status and may not see early psychosocial symptoms. If they do see these symptoms they do not know where to refer people to get the right services for their needs.

79 A GP can't go online and look at a mental health support directory, and refer their patient to a service, as such a directory does not exist. For example, in the UK there is a network of computers in public places, for the public to log on and search for mental health services and supports. These are called "wellbeing points". The wellbeing points enable users to access a health and wellbeing portal, thus enabling them to independently access local resources. Pre-existing publicly available computers, or online networks, are used, and are identified as wellbeing points using a large sign or an icon. Something similar to the "wellbeing points" could be developed in Victoria.

Is there a gap between the message that people should seek early help (when there are signs of mental illness) and actual availability/responsiveness of services?

80 My view is that there is a gap between the recommendation to seek help early and the available services, due to the barriers that exist in our system. People are unable to navigate what I see is a fragmented mental health system. In addition, our system struggles to look beyond the mental health condition itself to address the social determinants of health.

81 What is required is a new digital services that will focus on providing adults with mental health issues with access to early-intervention, preventative and skill building supports, to improve their well-being and long-term recovery outcomes. This digital service for adults with mental health issues should be developed, using and complementing online government-run portals, for example my.gov.au or Centrelink's website.

82 The establishment of a new digital mental health gateway (for instance, called "My Mental Health") should provide:

(a) digital counselling services to help adults with mental health issues to manage daily challenges, reduce stress and strain, and plan for the future;

(b) online peer support, connecting people with mental health issues with online trained (and supervised) peer supporters to provide knowledge and experience sharing, emotional support and mentoring;

(c) online coaching resources with simple techniques and strategies for goal-setting and future planning;

(d) access to a mental health directory service, providing assistance to help access relevant, local and targeted services; and

(e) educational resources to increase skills and reduce the stress and strain of adults with mental health issues, to build confidence, improve wellbeing, while reducing isolation, stigma or discrimination.

83 These new online services should be designed and tested in consultation with people with a lived experience and the sector.

In relation to the six PARCs that Wellways operates in collaboration with clinical health services:

Is supply keeping up with demand? What gaps have you observed?

84 In some areas they are some not. In our experience there are two major dynamics working. Firstly, in rural settings, the PARC and the person are not in close proximity to each other. Secondly, in metropolitan areas, there is high demand for inpatient beds in hospitals, meaning that great pressure is placed on PARCs to relieve pressure for acute inpatient beds.

85 There are three main gaps: people in regional and rural areas, women, and young people.

86 For example, the PARC service in Goulburn Valley is in Shepparton. This can be more than two hours away for people living in some areas of the catchment. Given the lack of transport and lack of resources typically experienced by people with mental health issues, on any practical level a PARC service may not be available. There are models where PARC services are much smaller home-like environments (Step-Up Step-Downs in the ACT, models from New Zealand) that could be made accessible to people across large catchments.

87 There are plans for 20 bed PARC services to accommodate women and young people. Wellways highly recommends that these PARCs be smaller and feel "non-clinical". They should not be located on hospital grounds. PARCs should not be stigmatising. Young people should feel confident to stay at PARCs, and women should feel able to bring their children.

88 Wellways supports the establishment of a network of smaller home-like PARCs existing in ordinary neighbourhoods across the state.

Are the PARCs operating as intended? If not, in what ways?

89 PARCs have two purposes:

(a) From a participant perspective, to provide a supportive and effective intervention that enables them to stay connected to community and minimise disruptions to their roles and routines when they are early in episode of mental ill health (Step-up), or in early recovery (Step-down, following a hospital admission).

(b) From a hospital perspective, PARCs are a bed management strategy. PARCs can mean that people avoid using beds, and they can discharge people earlier than otherwise. Both uses mean beds are freed up.

90 Both purposes aim to avoid hospital admission – this is experienced as restrictive and traumatising by most people.

91 In practice, however, the second purpose (bed management) can overshadow the first purpose. Participants can be discharged quickly to free up a PARC bed, and the environment can become increasingly "hospital like" as people with higher levels of acuity come into the PARC to manage bed pressure. Too often discharges from hospital occur on a Friday afternoon to make beds available for the weekend, providing less access to senior clinicians, senior staff at the PARC and causing an earlier and unplanned discharge from the PARC.

92 This dynamic means that the development of self-management skills, community connection, role recovery and family involvement – all the hallmarks of recovery – can be undermined by a clinical need to manage beds.

93 This is playing out in PARCs as clinical teams seek to increase their involvement, to enable people with higher acuity to be effectively managed.

Are the PARCs operating both as a Step-up and Step-down facility?

94 Yes; however, as the bed pressures increase and hospitals exert more control over the physical environment, it has meant that the units are more hospital-like. For example, the hospital wants infection control thinking to influence furniture and fittings, acuity to influence hanging point design. This risk framework then influences clinical control over the modes of intervention to illness management rather than problems with community tenure. Our overall impression is that the Step-Down function of PARCs is increasing.

Has the PARC program been evaluated? If so, what are the results of the evaluation? Against what criterion is the PARC program evaluated?

95 There have been several evaluations. DHHS initiated an evaluation about 12-15 years ago.

96 Further, research has shown that a Step-up/Step-down PARC can facilitate recovery for people with mental illness through promoting independence and illness self-management.[2]

Are there any limitations of the PARC program? If so, what are they?

97 Current contracting of PARC services in Victoria occurs via the hospitals. This places the hospital in the most powerful position to choose their NGO partner, and to dictate the model of care and resources allocated to the NGO. Various pricing models exist, ranging from about 50% of overall funding to about 68%. The higher the allocation to the NGO, the more innovation is possible; for example to support families, do community inclusion work, or develop a volunteer linking program.

98 Wellways supports a position where PARCS are contracted directly by the DHHS, but must operate in partnership with the local clinical service. This will equalise the partnership and enable coproduction of the model of care, with regard to policies, practices and processes.

Are there ways in which you think the need for services of the kind the Wellways provides is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

99 Wellways is aiming to change the focus from institutions to the community. Our social fabric is changing, so we need to think about how to put systems in place that support people in the changing landscape. We will continue to adapt to societal changes in the future. Our future services will be more tailored in relation to: multicultural groups, the Indigenous population, young people and children. It will also aim to address physical health needs. In addition, it will adopt greater use of digital technology. Co-production technologies will play a big role in helping us to achieve these outcomes.

In your experience, how does the complexity of the mental health system impact on people's ability to access services and navigate the system?

100 In my experience, people find it difficult to navigate Victoria's mental health system. This is not to say that mental health services should be run by a centralised body; rather, that we need a system that is connected. Attention needs to be given to developing a way to effectively navigate the system for consumers, and for those referring consumers to services.

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2 See, for example, Lee et al, 'Promoting Recovery via an Integrated model of care to deliver a bed-based, mental health prevention and recovery centre' (2014) 22(5) *Australiasian Psychiatry* 481.

In your experience, what has the commencement of the NDIS meant for access to psycho-social support programs?

101 We estimate that approximately one third of people eligible for NDIS do not end up receiving NDIS funding packages. People with social, cognitive and emotional impairments may find it challenging to meet the requirements to apply for the scheme.

102 There are also less and less services available for psychosocial support, due to discontinued funding of existing programs and services. This is because the NDIS assigns funding to individuals, meaning that traditional service provider agencies will lose their government contracts, and have to compete in a market environment to attract customers.

103 The Victorian Government defunded $110 million across the state for disability psycho-social services. As a result, Wellways lost funding for approximately half of its business in Victoria. The NDIS does not provide the services that were provided under the state funded model; the model, funding structure and services are different.

104 I estimate that nationally 68,000 will be funded through NDIS. This means about 14,000 will receive services in Victoria through this program, given that 148,000 people experience serious mental illness (**SMI**) in any one year, 138,000 people with SMI will miss out in Victoria.

105 The Victorian Government has since increased funding for mental health; however, the funding has not gone back to where it was taken from. For example, the new funding is directed to programs such as suicide prevention. It does not fund the type of psycho-social programs and services that Wellways previously offered. Prior to the introduction of NDIS Individual Client Support Packages (**ICSP**, formerly known as home based support) supported individual people in their own homes to gain, attain and keep the skills they needed to stay well in the community. Residential rehabilitation programs were also defunded. The staff were degree-qualified and focussed on psychological motivations and to develop strategies to build client owned solutions.

Has Wellways changed the way it provides services in response to the introduction of the NDIS and if so, how?

106 Wellways has been forced to change the way it provides services in response to the rollout of the NDIS. This is due to how NDIS services are defined, the price offered, and the NDIS understanding of what a recovery based service does.

107 Wellways has had to make 30-40 degree qualified staff, including graduate psychologists and social workers, redundant due to the NDIS funding model. Prior to the introduction of NDIS, over 60% of the staff we employed were full or part time.

Today, 63% are casual staff. The NDIS funding model does not provide adequate funding, nor expect evidence based psychosocial interventions. The funding it provides means that Wellways has to offer lower-paid jobs to less-qualified people to deliver a disability support item. There is no funding for sustained capacity building of the workforce at a State or Commonwealth level.

108 Wellways now employs people who are Certificate II and III qualified, in areas such as disability and health and safety, because that is what the NDIS funding allows.

109 As a result, Wellways now provides a different type of service. Wellways offers personal relationship training, whereas in the past we were able to offer skilled intervention. In addition, we now provide self-funded education in-house to up-skill our employees. Wellways does not receive any funding for this training.

In your experience, what are the complexities and challenges that confront the NGO sector in adapting to changes in funding models?

110 In my view it is likely to be the impact on staff. Service providers, and by extension their staff, face uncertain futures with governments discontinuing funding. They have to compete to attract customers who choose their services. In addition, my understanding is that many agencies have maintained their staffing levels, and have not responded to the NDIS funding model changes. In my opinion, a lot of these agencies will not survive unless they make higher skilled workers redundant and hire lower-skilled workers.

In light of your responses to the questions above, what changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

Access to treatment and services;

111 Additional focus on the community would help to bring about improvement.

Navigating the mental health system;

112 Systems need to be put in place, both in person and online, for people to be able to better navigate their way around the different services, for example an online directory.

Getting help to people when they first need it;

113 Increased funding for programs that support early intervention would help people to get help when they first need it.

114 This is essential as we know that psychosocial disability, for example social disconnection, precedes the acute onset of illness – and the level of psychosocial disability is a predictor of outcomes.

Strengthening the NGO sector?

115 One of the major issues is the decentralised tendering processes which have the effect of splitting the community by creating more space between one service and another. Each tendering body designs its own tender KPIs, and has little idea of what other agencies require. Each funder strives to ensure the applicant performs against the criteria set, and therefore sets up hard edges about what the successful applicant will and won't do. For example, as described earlier in this response a person has an average stay in PARC for 10-14 days. When the person is discharged there may or may not be an agency in the region to continue working on identified need. If there was a requirement in the tendering process that tenderers had to link with other services this would provide a much better outcome.

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

116 There is an absolute need for clinical services; however, there needs to be more of a focus on community supports. The community focus means continuing different service options and developing ways for people to effectively navigate the service options, both in person and online.

What do you think are the critical elements of a well-functioning mental health system?

117 Collaboration and integration are two critical elements of a well-functioning mental health system. In addition, funding should recognise the missing middle. As long as money is put predominantly into high cost activities such as bed based services, for example clinical treatment options, more beds, more clinical community treatment, everyone is going to be pushed to the pointy treatment end. Additionally, the creation of community hubs is again seeing the person only through a health lens rather than a whole of life lens. Of course funding needs to support an acute clinical system, but it must also focus on supporting people to live free from isolation in the community, or we will reproduce the current system

Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

118 The Royal Commission needs to be bold and recognise that the current mental health focus has come out of an institutional lens, and needs to be shifted to a community lens. There is more to the person than their health. Services must address psychosocial disability in a community setting, both prior to the emergence of illness, and in between episodes for those experiencing psychosocial disability. Funding should not be cut back in related areas such as housing, inclusion and education. These are situational factors that impact on mental health.

119 Mental health needs to be better valued like heart conditions.

120 There needs to be funding to integrate services and collaboration. Integration of services needs to be funded. The Partners in Recovery program is an example of a successful program that values integration.

sign here ►

print name Elizabeth Crowther

date 3/7/19

Royal Commission into
Victoria's Mental Health System

ATTACHMENT EC-1

This is the attachment marked 'EC-1' referred to in the witness statement of Elizabeth Crowther dated 3 July 2019.

Megan was referred to Wellways from the AOD worker at Wathaurong Aboriginal Cooperative. At the time Megan describes herself as *'struggling with mental illness, alcohol addiction and an inability to live with my family as they were causing harm to my physical and mental well-being.'*

Megan felt she could no longer live with her family so was referred to Wellways' youth housing & homelessness program. Within months of receiving support from her worker Lauren, Megan was able to secure a private rental property.

Megan stated... "*moving in to my new accommodation with just the clothes on my back and a few knick knacks, Lauren hooked me in with services who aid first home clients in obtaining the first home necessities. I was able to gain a fridge, microwave, washing machine, kettle and toaster. Lauren also charmed her way into getting me a couch that I wanted from Encompass for free!*

With the help of Lauren and another Wellways worker Matt, Megan was also finally able to purchase a car.

Megan is now applying to the Institute of Koori Education to do a Bachelor's Degree in either Social Work or Psychology.

Megan provided the following feedback about the support she received from Lauren:

"She has helped me tremendously with not just financial issues but psychological ones. She has encouraged me to flourish in my independence and self-reliance. Not only has she helped me gain life confidence but self-confidence as well. She has introduced me to new stress relief techniques that I will always value like meditation, mindfulness, exercise, healthy eating etc. Lauren has also boosted my problem solving techniques. I can go on and on about what she has taught me.

Lauren is extraordinarily pro-active. If there's a problem she will solve it. No problem or difficulty is too minor or major and if she is able to fix it she will. She is a master problem solver! She maintains a very humanly approach of communication. Lauren has an honest, no beating around the bush kind of attitude that I respect immensely. I value her counsel and wisdom. With a light hearted humour and spirit, it's hard not leave an appointment with her without a laugh!

I now have a place to call home, all the necessities, furniture and items I need. A part time job and car. I do not drink nor smoke and have been more stable than I have ever been in my life. Before Lauren's support, I was a very lost individual. I guarantee that I would not be where I am today without her and I feel truly blessed to be connected with Wellways and a worker as fantastic as her. Looking back on all the achievements that I have made with her help is empowering and truly makes me happy."

Wellways is now supporting Megan to attend the NAIDOC ball, an important event hosted by Wathaurong Aboriginal Cooperative.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT EC-2

This is the attachment marked 'EC-2' referred to in the witness statement of Elizabeth Crowther dated 3 July 2019.

wellways

Inclusive Communities Initiative (ICI)

Providing a new digital mental health gateway and coordinated support for adults with severe and persistent mental health issues

This document was developed by Wellways Australia, 276 Heidelberg Road, Fairfield Vic 3078.

1. Policy Context

Around one in five Australians experience mental health issues at some stage in their life. Mental health issues accounts for 13 per cent of the total burden of disease in Australia, and is the largest single cause of disability, comprising 24 per cent of the burden of non-fatal disease. Around 600,000 Australians experience severe mental health issues and approximately 60,000 have enduring and disabling symptoms with in-community multi-agency support needs. The ***Inclusive Communities Initiative*** (ICI), encapsulating a ***My Mental Health*** digital gateway and an ***Inclusive Communities Model*** (ICM), targets the more than 250,000 people in this group.

Addressing severe and persistent mental health issues requires a complex system of treatment, care and support, requiring the engagement of multiple areas of government, including health, housing, income support, disability, education and employment. The Australian and state/territory governments as well as the non-government sector, all deliver programs for people with mental health issues and their carers. Building a coherent system of support is a challenging task.

One of the most consistent themes repeatedly fed back to Government is that care for the most vulnerable people with severe and persistent mental health issues is not adequately integrated or coordinated, and people with complex needs often fall through the resulting gaps.

Community mental health services are a vital part of the mental health system, providing care in a community setting to people with severe mental health issues and a psychosocial disability. Community mental health services provide early intervention when people become unwell, and also support people to return to their community from more acute settings like hospital. Community support is a cost-effective intervention because it can help to reduce costly hospitalisations and time away from work.

Community-based collaborative care models build a team of professionals around a person experiencing mental health issues, including GPs, psychiatrists, support workers and allied health, housing, education and employment agencies. There is strong evidence that this type of model of care improves health. Economic modelling indicates that this intervention can deliver a return on investment of $3 for $1 invested.[1]

2. Policy

It is proposed that the ***Inclusive Communities Initiative (ICI)*** be funded in the 2020/21 Federal Budget to provide a) $17 million (over three years from 2020/21 to 2022/23) to support the establishment of ***a new digital mental health gateway*** (working title: ***My Mental Health***); and b) $750 million (over five years from 2020/21 to 2024/25) to support the ***Inclusive Communities Model (ICM)***, to provide coordinated support and flexible funding for people with severe and persistent mental health issues.

2.1 My Mental Health: digital mental health gateway

It is proposed that new digital services will focus on providing adults with mental health issues with access to early-intervention, preventative and skill building supports, to improve their well-being and long-term recovery outcomes.

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[1] Mental Health Australia (MHA) and KPMG 2018. *Investing to save: The economic benefits of investment in mental health reform: Final Report*, Canberra, May 2018.

These new services form part of the ***Inclusive Communities Initiative (ICI)*** that will provide people with mental health issues with in-community supports and services.

Implementation of the ***Inclusive Communities Initiative (ICI)*** should be undertaken in two phases.

First, a new digital service for adults with mental health issues should be developed, using and complementing the Australian Government's Centrelink "MyGov web portal (my.gov.au). The establishment of a new digital mental health gateway (working title: ***My Mental Health***) should include:

- digital counselling services to help adults with mental health issues manage daily challenges, reduce stress and strain, and plan for the future
- provide online peer support, connecting people with mental health issues with online trained (and supervised) peer supporters to provide knowledge and experience sharing, emotional support and mentoring
- online coaching resources with simple techniques and strategies for goal-setting and future planning
- educational resources to increase skills and reduce the stress and strain of adults with mental health issues, to build confidence, improve wellbeing, while reducing isolation, stigma or discrimination.

These new online services should be designed and tested in consultation with people with a lived experience and the sector.

2.2 *Inclusive Communities Model (ICM)* of Care

Secondly, in collaboration with the establishment of a new digital mental health gateway, the ***Inclusive Communities Model (ICM)*** of Care should be established to provide coordinated support for people with severe and persistent mental health issues across Australia to help them access local and targeted services.

The ICM aims to better support people with severe and persistent mental health issues, and their carers and families, by getting services and supports from multiple sectors they may come into contact with (and could benefit from) to work in a more collaborative, coordinated, and integrated way.

The objective of ICM is to improve the system response to, and outcomes for, people with severe and persistent mental health issues by:

- facilitating services to deliver 'wrap around' care individually tailored to the person's needs;
- strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the ICM target group; and
- promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental health issues.

Implementation of ICM should be governed by a number of key principles, including:

- Recovery oriented and participant focused - ICM should operate under a recovery framework using a personalised approach tailored to address the specific support

requirements of an individual and assisting them to maximise their capabilities through social and environmental opportunities.

- Flexibility in roll out – how ICM operates from one region to the next may look different, as a result of participating organisations tailoring their model to best meet the needs of the ICI target group and existing service delivery systems in each Primary Health Network (PHN) region.
- Complementary to existing service systems – participating organisations will assist with, rather than complicate or duplicate, system navigation. The initiative is not to address issues of service availability but focus on multi-service integration and coordination to drive better outcomes for the vulnerable people with mental health issues.
- Better coordination of systems – the initiative is not intended to offer a new 'service' in the traditional sense. Rather, it will assist in better coordinating existing services and supports. ICM will provide a 'support facilitation' service focusing on building pathways and networks between the sectors, services and supports needed by the ICI target group.

2.2.1. ICI participant target group

The initiative will focus on adults who have a severe and persistent mental health issues that require a response from multiple agencies. These individuals have persistent symptoms and significant functional impairment, and may have become disconnected from social or family support networks.

This can lead to extensive reliance on multiple health and community services for assistance to maintain their lives within community-based settings and outside of institutional care. They may have comorbid substance use or physical health issues or both, are likely to experience difficulties maintaining stable accommodation, and experience difficulty in completing basic activities of daily living. These individuals are reported to often fall through the system gaps and require more intensive support to effectively address their needs.

It is anticipated ICI participants will generally be in their mid-twenties and older, reflective of the typical development of severe and persistent mental health issues. The initiative recognises there are a range of Government sponsored programs, such as the Early Psychosis Prevention and Intervention Centre (EPPIC) program and headspace, aimed at early intervention for young people who may be developing a mental illness that aim to reduce the risk of long term disability. The initiative is to focus its supports on adults who have severe and persistent mental health issues.

3. Service coordination and integration

The range of sectors, services and supports that should be coordinated through ICI should adequately reflect the existing suite of sectors, services and supports within each region that are required by the ICI target group.

Participating organisations should bring these sectors, services and supports together to promote collective ownership by all partners and encourage the development of innovative solutions to ensure effective and timely access to the appropriate services and supports required by ICI participants to meet the full range of their needs and to sustain optimal health and wellbeing.

Private, government (Commonwealth and state/territory), and non-government services and supports expected to be involved may include, but not be limited to:

- Public community and specialist mental health services;
- Private psychiatrists and psychologists;

- Primary (e.g. GPs), secondary (e.g. OTs, optometrists, diabetes educators, dental) and tertiary (e.g. hospitals, specialists) health care services;
- Alcohol and other drug treatment services;
- Disability services;
- Income support services (e.g. Centrelink as administered by the Department of Human Services);
- Supported accommodation services and other accommodation providers;
- State/Territory public housing;
- Personal Helpers and Mentors Program providers;
- Support for Day to Day Living Program providers and providers of other relevant community based living skills programs;
- Parenting support services;
- Vocational rehabilitation services;
- Education and employment services; and
- Child protection, domestic violence and justice services.

4. Role of ICM Participating Organisations

It is intended ICM participating organisations will work at a systems-level and be the mechanism to drive collaboration between relevant sectors, services and supports within the region to ensure the range of needs of people in the target group are met. This will be achieved through the development of innovative solutions discussed and collectively owned by ICM participating organisations grouped within each Primary Health Network (PHN) region. Support Facilitators will undertake the day to day tasks and develop the partnerships and relationships required at the individual level to support this.

In undertaking their roles effectively, ICM participating organisations and their staff (including Support Facilitators) will need to:

- build and maintain effective relationships and partnerships and have strong networking ability;
- be confident in the appropriate use of authority (with participants and with the range of service providers within the region);
- have strong communication and negotiation skills;
- have capacity to:
  - engage with people who have often been difficult to work with;
  - share experiences and information;
  - analyse and formulate assessment/plans;
- have experience within and understanding of clinical/health and/or welfare service and support systems;
- have an understanding of mental health issues and/or experience working with people with severe mental health issues; and
- encourage a recovery-oriented culture and possess personal qualities such as humane concern, empathy with both the participant's issues and service provider experience, imagination, hope and optimism.

5. Funding

The initiative recognises that the allocation of funding should not be meant to be sufficient to meet the acute health care and intensive social support, education, employment and housing needs of ICI participants on an ongoing basis.

- ICM participating organisations will need to establish an expectation that ICI participants will be serviced by the existing network of providers.
- ICM participating organisations should also seek of the availability of any other funding sources which they could be eligible to use to supplement ICI funding.
- ICI participants should access services available within the existing network of service providers, rather than build a reliance on the ongoing funding.

6. Proposed Budget:

Inclusive Communities Initiative (ICI):

$17 million (over 3 years from 2020/21 to 2022/23)	Digital mental health gateway (working title: My Mental Health)
$750 million (over 5 years from 2020/21 to 2024/25)	Inclusive Communities Model (ICM) of Care

Further Information:

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