SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Creative Public Health Solutions

Robyn Minty, Principal Consultant

July 2019

About the author

Robyn Minty (MPH) is the principal consultant for Creative Public Health Solutions, providing innovation and creative co-design thinking leadership for large scale Policy & Program development needs. With more than ten years' professional experience inclusive of nursing and education with major disciplines-sexual health/mental health; she is well placed to contribute to the analysis on reform and the mental health system. Large scale policy and program development has been a central focus for her work in a variety of cultural settings including work internationally, especially focused on gender equality.

Robyn has had a long standing interest in systems change and has experience working with government and NGO sectors to review systems change challenges at a policy and program level.

Working with teams, leading co-design practice for solutions to large scale issues, Robyn aims to lead, advance and grow systems change by providing expertise in high level technical analysis/reporting, critical thinking and best practice consultation approaches – building mutual understanding.
email: LinkedIn@creativepublichealthsolutions

RESTORING THE SYSTEM TO GOOD HEALTH

INTRODUCTION

This submission is focusing on the mental health system changes required to reform at a governance level, with particular focus on policy and program development.

Experiences of mental ill-health will affect almost half of the population in Australia within their lifetime, with an estimated 20% of the population (over 4 million people) experiencing mental ill-health in any given year. Experiences of mental ill-health vary dramatically in severity and duration, with experiences of severe mental ill-health occurring in 2–3% of the population in any given year[1].

Mental health is an emerging health policy priority globally. The emphasis on closing the treatment gap in psychiatric services is now being complemented by an increasing focus on prevention and health promotion[2]; challenging funds distribution. Decision makers must review the economic decisions that have driven fragmented health systems over time – they must rebuild an efficient and effective system that will meet growing population mental health needs.

At a time when the world faces a growing number of public health challenges, including mental health, governments are urged to take action. As a state lead, Victoria can provide a roadmap for change at all layers of the system including the mechanisms of government, which for too long have never been questioned nor challenged nor reformed.

Testimonial

Delving into the deeper layers of health systems requires cooperation and a political appetite for change – not always perceived as a popular move. Challenging though it was, the foundational Health Promotion Policy in this war torn country was later rewarded by positive outcomes in health system progress being recorded[3]. It was my humble task, guiding the analysis of the secondary health data with a gender lens and supporting a consumer's mental health perspective to those results.

16 million of 25 million were young people under age 24 – this was notably my 'alarm bell moment' - maternal health and the young male population rates of accident deaths and morbidity (domestic, road and agriculture) were indicated by the population groups on gender analysis. The deeper layer analysis conducted with a mental health lens is unable to be reported here, however in summary, the core issues indicated perinatal mental health and post trauma mental health indicators (especially for males) as concern. For the first time in this country mental health had been given in-depth attention[4].

The idea that mental health promotion could be possible in this developing country was challenging the thinking of those engaged in the process. On reflection, whether it was because of my work delivering the *Mind Matters*[5] Program since 1999 or responding to the Suicide Prevention strategies since the first *Suicide*

Report 1996[6] or my learnings and experience as a secondary school nurse DHHS[7] – I had taken the view that in order to reduce the numbers of people with mental ill health falling through the gaps, mental health had to be a core pillar of reviewing data in any analysis. I had taken to placing emphasis on mental health in all policy and programs in my health promotion practice.

As a result, two standout mental health promotion issues were prioritized - perinatal health issues and young people's mental health needs, a huge task was ahead for a country that had 16 million people under the age of 24, young people (as young as 10-14) moving to cities for work or caring for families who had lost the main bread winner to war or poor health. Further discussion and analysis was considered, the results were outside the norm for health promotion modeling – deemed relevant in well developed countries yet all too difficult to apply to this work.

Religious leaders, government, *Save the Children* NGO staff and key UN leaders workshopped with the 50 regional/metro community liaison officers (liaisons were community members who received only in - service based health training as married couples who lived and worked in their village acting as a liaison for health ministry messaging) – this was the first type of consumer lived experience gathering of any health issue. Key questions were designed to support the analysis and consultation in context with the key strategic areas, and together we examined perspective and medical examples – developing policy principles, action items and an action plan for implementation.

As a result of challenging the thinking and reviewing of the deeper layer of the systems – gender transformative practice and mental health promotion were embedded in principle for policy to practice. Changes were radical, for example the religious leaders developed a protocol allowing women to attend antenatal care without their partners (supported by community liaisons),this expanded opportunities for better access for health promotion with regard to mental health and parenting. The government supported this shift in policy approach and religious leaders thought outside the square – since then the perinatal mortality rates have reduced (not to mention also that childbirth deaths have reduced).

Further, Mental health first aid training was provided to all community liaison couples and many prevention activities have been in- serviced since. As more hospitals were built (five still standing at time of this report), mental health promotion strengthened – trauma history was acknowledged and young people were able to get the help they needed where they lived. Art, sport and music has since emerged as an accepted funded health program delivery point (although limited).

Often systems reform is a complex interaction between public policy and practice, requiring a understanding about thinking models that may influence decision making. These decision makers can respond in various ways despite the focus on obvious inequities. It can be mutually reinforcing or in conflict with political will or appetite for change. In this case, even with intense debate, the consumer health needs took front and centre. I reflect on what I witnessed as a willingness to shift attitudes and preconceived ideas of policy work and expected outputs to a collective response to co-produce something that actually would work on the ground. This event in time could possibly be considered the most humble and innovative act of any Parliament ever seen globally.

PUBLIC HEALTH CONNECTS US ALL

Public health works to limit health disparities. A large part of public health is promoting healthcare equity, quality and accessibility by working towards strengthening local and state public health departments and promoting proven health programs[8,9].

Good health enables people to be more productive and higher productivity, in turn, reinforces economic growth. A healthy population requires less of government expenditures on income support, social services, health care, and security.

In 1986, the Ottawa Charter for Health Promotion later followed by the Jakarta Declaration 1997, captured the shift in public health's focus from individual risk factors and behaviours to the societal conditions that keep people healthy: factors like adequate income, meaningful work, education, community connection, decent housing, and healthy food. Prevention and Promotion in Mental Health has consequently been part of the conversation ever since.

Rising numbers of people all over the world are exposed to armed conflicts, civil unrest and disasters, leading to displacement, homelessness and poverty. People exposed to violence are more likely than others to suffer from mental disorders such as post-traumatic stress disorder and depression, possibly leading to drug and alcohol abuse and increased rates of suicide[10].

The likelihood of mental health problems increases exponentially where there are other indicators of vulnerability such as unstable housing and poverty, neglect and abuse, intergenerational trauma or developmental disabilities. Intervention early in life, and early in mental illness, can reduce the duration and impact. Early intervention is especially important for children and young people because many mental health problems can affect psychosocial growth and development, which can lead to difficulties later in life[11] .

Aging population and the raised awareness of trauma history relating to mental ill health will need critical national response. Further; women, LGBTIQ, 'new arrivals' and youth will continue to fall through the gaps in services, creating a chasm of vulnerable groups experiencing poverty, loneliness, homelessness and poorer health outcomes, leading to risk of suicide.

It is expected that the Royal Commission will receive a comprehensive record about the magnitude of the issues and wicked problems, but to restore the mental health system to good health we must not only understand the problems but understand how and what shifts them. After repeated government enquiries such as the Burdekin Report 1993, similar problems have hindered progress. But what are they, we ask? This review should challenge the reform of mental health system structures as well as the system thinking – a thread that must be taken up if sustainable change is to be achieved. We cannot underestimate what is required to shift the conditions that hold these problems in place - perhaps the notion that "mental health in all policies"[12] needs to be taken up[13].

Research tells us that by addressing these social determinants, we can improve people's health and well-being and reduce health inequities.

Despite efforts at the federal, regional, state and local levels, health disparities persist and continue to widen in some populations[14].The tangible and intangible costs associated with health disparities are significant, contributing to loss of life, early death, disability and inefficiencies in the system.

There is a downward shift in Victoria's mental health performance reflecting many of the challenges facing the mental health system in Australia as a whole. The experience of Victoria is illustrative of issues that need to be addressed. Several key measures demonstrate the severity of mental health system failure in Victoria:

- 13% below national average expenditure per capita on mental health services;
- Only 1.1 per cent of Victorians receive clinical mental health care – 39% lower than the national average;
- Over 90,000 Victorians experiencing severe mental illness each year do not receive the care they need;
- Only a very small proportion of the estimated 150,000 people experiencing severe mental illness each year will be eligible for the National Disability Insurance Scheme (NDIS); and
- Two out of every three young people in Victoria who need mental health services are currently being turned away.
- 40% below national average access to mental health services.[15]

The impact on individuals mental health seems a miserable commentary; the consequent disparity due to chronic widespread underfunding, calls for a total overhaul and upgrade to the mental health system.

1. Fund policy action principles

To eliminate health disparities and move the needle toward health equity, mechanisms are needed to ensure we operate with consistent application of best practice policy development and evaluation.

We know that gender interacts with other social determinants to influence health and wellbeing, patterns of illness, and behaviours specific to different groups of women and men. Policy in mental health needs to be broader, inclusive of societal disorder, recognising that meaningful reform can occur inclusive of urban contexts, housing, environment and food security.

Developing effective strategies to improve health for vulnerable and under-resourced populations challenges researchers to examine how policies, both historic and contemporary, perpetuate health disparities. The existing funding arrangements create fragmentation to

considering effective analysis; affecting public policy and service equity. The implementation of realistic funding models is of national economic concern[16].

Gender equality brings significant economic, social and health benefits for Victoria[17].It also introduces 'systems thinking and asks us to think about the larger, interconnected society we are a part of and how these connections impact our health'.

The state needs to drive gender equality for mental health promotion, prevention and early intervention as a priority. Current funding approaches have created gender inequality on a grand scale - gender blind reporting is one example of this, a neutral evidence base – limiting the foundation for programs based on gender sensitive practice. The mechanisms of government for gender equality need to be consistent and enshrined in the structures and function of its public service. Data collection and reporting as well as the execution of commissioned work, funding programs and developing policy and guidelines all need review for the presence of gender lens practice. As practice is intrinsically linked to policy - change will occur if we ensure that practice reflects the elements necessary for mental health to be accessible for all.

Further, gender mainstreaming was acknowledged as an indispensable strategy for achieving gender equality at the 1995 Beijing Platform for Action.

The 1995 Beijing Platform for Action called for the end of gender inequality through a range of actions including gender mainstreaming policies, gender assessment of policy impacts, and preparation of national budgets and programs to ensure that resources are allocated to support programs and policies beneficial to women. This call has been amplified in several international declarations and conventions, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Good practice example:

The budgetary principle of promoting gender equality was incorporated in the Austrian Constitution in 2009. From 2013 on, for the very first time, the annual Federal Budget Act – a key government document – shows the medium-term political outcome objectives aimed at gender equality by Ministries and other public bodies. The objectives are result oriented by being measurable through yearly monitored and evaluated key indicators which address identified gaps. The "Annual Report on Outcome Orientation" delivers the evaluation results – the progress made in gender equality – to Parliament for discussions and political control. This reform of public management resulted in the development of a comprehensive gender-oriented budget and reporting framework, which has been integrated in the government's performance budgeting system. This is how gender mainstreaming is directly linked with policy making and management across all areas of policy[18].

Clearly gender mainstreaming is a broad and challenging agenda that requires a strategic and targeted approach in order to achieve impact and meaningful outcomes.

Starting with Australia, in 1984 where the government was required to assess budgetary impacts on women and girls [Elson, 2006]. Gender budgeting is important because it identifies gender related needs in different policy areas as well as the gender-specific impact of policies allows the government to target resources more effectively to promote gender equality and ensure that policies do not negatively affect equality[19].

The Victorian Gender Equality Bill 2018 has reinforced this approach but has not gone far enough. To ensure gender mainstreaming is embedded in our society so equality can be achieved; a stronger focus on outcomes performance, budgeting, disaggregated data collection and reporting is needed across all health systems. Gender budgeting should be viewed not just as an 'essential tool for assuring implementation and impact, but also as critical for strengthening policy processes'[20]. It should start at Treasury and link with key program performance and strategic organisational structure measures.

Budgeting linked to gender will create equity across a myriad of pillars in the mental health system, from service planning to 'reframing and strengthening inclusive policy making processes, recognizing the importance of political support and action; addressing systemic issues including data gaps; allocating budgets to support more robust impact analyses, policy design and implementation, and accountability for results; and, addressing data gaps to achieve the requisite outcomes and impacts'. It could also bring a revised structure to the rollout of the NDIS, where gender and cultural lens has been sadly lacking since its inception.

Recommendation 1: that the state increase **funding** to prevention of mental ill health.

Recommendation 2: that the state adopt a **gender analysis as a key principle** in policy development of all policies associated with improvement of societal conditions.

Recommendation 3: that the state adopt **gender budgeting as a key principle** in policy development of all policies associated with improvement of societal conditions.

Recommendation 4: that the state emphasize gendered data be **collected and also reported publicly**.

Recommendation 5: that gendered data be collected as a way of indicating improvements when **evaluating** policy progress and implementation and progress.

Recommendation 6: that **realistic funding models** and funding distribution mechanisms to achieve intended population mental health outcomes be established for the long term.

Recommendation 7: that the **judicial system** take note of its intersection with mental health and be more responsive to policy actions and keep in step with reform mechanisms to ensure gaps in justice delivery are minimised.

Recommendation 8: that the state have **funding mechanisms** that respond with certainty in relation to judicial reform – minimising lag time for structural responses for service delivery to be actioned.

Recommendation 9: that the ***Mental Health Act*** 2014 be reviewed to ensure its relevance, in particular Forensic services structure and function.

2. Build capacity for upskilling public service and health workforce

Sufficient skills to conduct proper gender analysis and integrate findings in the planning process must be a workforce capability for policy makers, analysts and planners, this will enable effective execution.

Without such a perspective, their effectiveness may be jeopardized, and inequities in health between women and men are likely to increase. Although the dynamics of gender inequalities are of profound importance, gender biases in health research, policy and programming and institutions continue to create a vicious circle that downgrades and neglects gender perspectives in health[21].

Governments should commit to workforce training to ensure decision makers incorporate a gender perspective into policies. Ideally, it should be done at an early stage in the decision-making process so that policies can be changed or abandoned if necessary. Although there are some policies where it is clear that gender plays a central role, there are other policies where the relevance of gender is less obvious. These are as a result sometimes labelled gender-neutral, for example health and safety and regional or town planning. In these examples, it may be tempting to see such policies, goals and outcomes affecting people as a homogeneous group. If policies are mistakenly perceived as gender-neutral, opportunities will be missed to include the views of different groups of women and men in policy formation and delivery and, in turn, to misjudge the different effects on each group, and the systems and organisations that support them[22].

In addition to hiring experts to draft policy papers, mental health experts should also be the Consumers who have lived experience. Consumers should be invited to co-produce policy and other key strategies anywhere in the policy/program/judicial space. They could be upskilled for specific projects or roles, bringing depth to the whole process. Mental models bring depth to policy making[23], Consumers with lived experience should not be just an add-on staff member, their experiences and perspective challenges peoples stereotype thinking, shifts attitudes and opens up possibilities.

A whole of government strategy for a workforce model like this could have a profound affect on employment and bring new dimension to productivity across the sectors. Further, as a new understanding of workforce teams would emerge, many peripheral matters of workforce and education could be reviewed. For example, sick leave conjures up issue – it should be reformed to 'wellbeing leave' as we have to challenge the stigma about mental health however we have systems in place that perpetuate negative behaviours in our society based on entrenched ways and poor attitude. A total systems reform has empowered tentacles of positive change and creates harmony at the intersectionality of mental health.

Recommendation 10: that develop a strategic policy and program **workforce strategy** that builds capability in gender analysis and impact assessments.

Recommendation 11: champion and encourage Consumers with lived experience to be employed as **equal employees** in all health departments to ensure mental health perspectives are embedded and supported in all public policy execution.

Recommendation 12: invest time to examine the structures and function of the **mechanisms of government** to ensure they are robust, fair and strategic for sustainable reform.

3. Increase focus on mental health prevention

Our current health system is largely focused on cures and treatments – the challenge has been how to engage governments in long term planning for prevention health models when their outcomes seem well into the future.

Mechanisms of government need a stronger focus on policy to practice, systems that include key indicators of systematic improvement and outcome measures that result in evidence informed prevention services and direct care being applied with a robust implementation methodology[24].

Further, the *Public Health & Wellbeing Act* 2008 implies that state and local councils together are accountable for the 'development of public health policy through …. municipal public health and wellbeing plans, a State public health and wellbeing plan and in some circumstances, health impact assessments'[25]. Governments need to focus on the performance of these municipal plans with people centred planning in mind, as municipal leadership on mental health is key.[26]

Recommendation 13: **fund public health** professionals to work more closely with experts in other fields: architects, planners, policymakers, social scientists, trac engineers, developers, law enforcement officers, economists, social marketers, and others[27]

Recommendation 14: fund all health programs state and local level on the basis of **key outcome indicators** for gendered mental health.

Recommendation 15: that gender mainstreaming is a core principle of future **legislation** to ensure consistency in state and local governance.

Prevention mental health programs need to be available to all children and youth. To designate mental health programs that work (such as the Sec. School Nursing Program) to only disadvantaged communities is unfair. Mental ill health can touch the life of anyone in our community. Efforts should be made to advance the reach of mental health prevention programs that are best practice to community health services centres and education sectors. As an adjunct to this action mental health services at the tertiary layer will need resources in keeping with expansion of prevention services.

There is also scope for collaboration with a more connected and coordinated mental health prevention work where communities and government work together on key areas of prevention[28].

Recommendation 16: fund **broader sector collaboration** to improve mental health prevention (eg CTC -underpinned by social development strategies, implement FRIENDS as core curriculum statewide, provide school nursing prevention programs in every school)

Good example practice:

In 2002 I represented the Nursing department (DHHS) in the Communities that Care Program. As a result of this commitment I also led Friends for Life program initiative as a response to a whole of school approach to mental health prevention. As a result of the hard work and collaboration of schools, agencies and the community and youth, my district experienced positive and fast changing improvements in the data collected by CTC.

Communities That Care (CTC) is an evidence-based, community-change process for reducing youth problem behaviours, including harmful substance use, low academic achievement, early school leaving, sexual risk-taking, and violence. The CTC approach applies the most up-to-date knowledge and research to foster healthy behaviour and social commitment among children and youth. https://www.communitiesthatcare.org.au/

The CTC process uses an early intervention and prevention framework to guide communities towards understanding their local needs, identifying and setting priorities, and implementing effective evidence-based strategies to address those needs. CTC follows a five-phase process to increase community readiness for prevention. Since 2002, an increasing number of communities across Australia have begun implementing the Communities That Care process to improve health and behaviour outcomes for local young people.

A program aligned with CTC strategy is FRIENDS for Life

FRIENDS for Life (FRIENDS) is a 10-session cognitive behaviour therapy program designed to prevent anxiety and depression in children and young people. The program teaches practical behavioural, physiological and cognitive strategies to identify and deal with anxiety that children and young people experience. The program also builds emotional resilience and promotes self-development. FRIENDS is effective as a treatment or as a school-based prevention course, and can be delivered by teachers in a school system.

Community indicators: Mental health problems in children and adolescents & Depressive symptoms in late primary school

4. Champion coordination and collaboration state by state

Efforts to coordinate action on national priorities have been made through multi-jurisdictional bodies, like the COAG Health Council and the Australian Health Ministers' Advisory Council. Despite this, governments can, and often do, make decisions without proper consideration of the flow-on effects on other levels of government[29].

The fragmentation within the system affects patients in a real way, particularly evident in areas like mental health, where patients are required to navigate an overly complicated system. Stakeholders have expressed frustration that Commonwealth and State and Territory involvement in similar areas is usually poorly coordinated. The result is duplicated effort, wasted taxes, and poorly targeted programs - especially in areas like mental health and drug and alcohol support.

The mental health system is also fragmented at the private sector layer of service delivery. Private mental health seems to predominantly operate outside the public sector regulation and guidance. This seems incongruous with the public policy purse strings. Funded guidelines meant to bring equity and sustainability for inpatient care for example do not include the private health sector resulting in limited compliancy and consistency of clinical practice (example being *Gender Sensitive Safe Practice Guidelines* (2011), Department of Health and Human Services, Victoria State Government). There is a 'significant lack of research into the private mental health sector'[30] and the concept of self-auditing in the private sector brings another risk for delivery of systematic care, public policy is not monitored nor is it enforced.

Recommendation 17: that greater collaboration occurs between the **private sector** and governments so policies and associated funding indicators be consistent in practice for the mental health system.

In any Federation there is a degree of overlap and duplication in the roles and responsibilities of the different levels of government[31]. We will need to improve the way the Commonwealth and the States and Territories work together, so the ways they exercise their roles and responsibilities are not at cross-purposes, and ultimately deliver better services for all

Australians. If we adopt a 'whole-of-government and whole-of-society approach to promoting population mental health and well-being'[32], we may be able to engage in effective action, reduce the duplication of effort and funding access and make a systems change that shifts the conditions that impinge on positive health outcomes. Establishing durable funding models has been cited[33].

Recommendation 18: work more closely with Federal and other states to reduce tax waste and improved national health schemes (both **Medicare & NDIS**).

Recommendation 19: champion **research** to review what it could mean to have a 'mental health in all policies' approach.

CONCLUSION

This submission is based on the combined research, evidence and practice experience of the senior consultant, Creative Public Health Solutions. To keep funding the system without interrogating the mechanisms of government may have long term effects on funds sustainability. Rather, governments should review the structures and functional processes that they use to perform the execution of policy and program practice. By conducting this scrutiny on how healthy the mental health systems mechanisms are, they will be able to confirm to the people of Victoria with confidence that the recommendations made by this Royal Commission will actually work.

Most importantly, as a result of the Royal Commission, we would like to see a system that is better connected and joined up and where under-resourcing is corrected especially in mental health prevention resourcing. There is a hope for a less patchy and less reactive system that upholds and respects peoples' human rights and enables their recovery.

Recommendations listed

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Recommendation 9: that the *Mental Health Act* 2014 be reviewed to ensure its relevance, in particular Forensic services structure and function.

Recommendation 10: that develop a strategic policy and program workforce strategy that builds capability in gender analysis and impact assessments.

Recommendation 11: champion and encourage Consumers with lived experience to be employed as equal employees in all health departments to ensure mental health perspectives are embedded and supported in all public policy execution.

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2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Ms Robyn Minty

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"mental health needs to be taught better in schools mental health first aid should be core to first aid training courses public staff eg librarians, bus drivers etc need basic training to be able to recognize mental health issues"

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
programs that empower people in the community work best

What is already working well and what can be done better to prevent suicide?
"the lifeline is always good, the media mention it alot now so this has improved the community awareness trauma history needs to be supported better - especially children of those families that have experienced stolen generation & family violence "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"accessibility to doctors who are on medicare, increased number of medicare mental health counselling sessions"

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"lack of services eg rural regional, cultural barriers, gender "

What are the needs of family members and carers and what can be done better to support them?
they need to feel heard

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
better training and wages more accountability for their actions emotional support at the clinical end consistent dr and medical models

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

not sure

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
reform of the govt process

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
reform of the govt processes

Is there anything else you would like to share with the Royal Commission?
N/A