Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ANNE LYON

I, Anne Catherine Lyon, Executive Director, of 18-20 Prospect Street, Box Hill, in the state of Victoria, 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.

2 I am authorised to make this statement on behalf of the Eastern Melbourne Primary Health Network.

Current role and background

3 I am the Executive Director of Mental Health, and Alcohol and other Drugs (**MH&AOD**) at the Eastern Melbourne Primary Health Network (**EMPHN**). In that role I manage:

(a) the commissioning and procurement of primary mental health services, alcohol and other drugs (**AOD**) services, and Aboriginal mental health services for the EMPHN;

(b) the strategic direction on integrated service planning and development across the EMPHN;

(c) the development and implementation of strategy and business plans, accountability mechanisms, clinical governance and stakeholder engagement;

(d) the development of strategic partnerships with key stakeholders including funding entities, Local Hospital Networks, General Practice and a range of community sector agencies.

4 With regard to the place-based suicide prevention trials, I have overarching responsibility for the team based at EMPHN working in the Whittlesea and Maroondah trials. They are part of the MH&AOD Directorate and report to a manager within the team with regard to their work. In this capacity, I review the team's reports prior to submission to the Department of Health and Human Services (**DHHS**).

5 I am also a member of the Project Steering Committee for the place-based suicide prevention trials convened by the DHHS. This committee comprises of senior PHN and DHHS representatives to provide high level guidance and oversight of the work of the trials, review activity of the trials (via regular update reports), provide advice on issues identified through the trials which DHHS then actions.

6 I started my professional life in health with initial qualifications in nursing. In 2000, I became a Project Manager for the Department of Human Services for the State Disability Plan. In 2005, I became the CEO for the Knox Community Health Services. I have since worked in various senior roles in primary care and community care services.

7 Attached to this statement and marked "**AL-1**" is a copy of my CV, which sets out my previous roles and qualifications in detail.

What is the EMPHN?

8 The EMPHN is a not for profit organisation funded by the Commonwealth to commission a range of health services including mental health services. These services include mental health stepped care responses, psychosocial support and community based support.

9 The EMPHN is one of 31 Primary Health Networks (**PHNs**) nationally. The PHNs were established to plan and commission a range of primary health services to meet the needs of their population. The key objectives of PHNs are to increase the efficiency and effectiveness of medical services to patients, particularly those at risk of poor health outcomes, and to improve the coordination and integration of services to ensure that patients receive the right care, in the right place, at the right time.

10 The PHNs operate in defined geographic catchments and work with key services such as hospitals, community health services and local GPs. PHNs are also involved in local service networks. Consequently, the PHNs are well placed to bring together local stakeholders and community members to identify gaps and opportunities for suicide prevention.

11 With regard to mental health services, PHNs are required by the Commonwealth Department of Health, through their funding arrangements, to lead mental health and suicide prevention planning, commissioning and integration of services at a regional level to improve outcomes for people with, or at risk of, mental illness or at risk of suicide.

12 The Commonwealth Department of Health specifies the types of services to be delivered (through a range of guidance documents) and EMPHN decides how they will be delivered.

13 These services must align with the Australian Government's response to the 2014 report of the National Mental Health Commission, *Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services,* which recommended a stepped model of care for mental health, and made 25 recommendations across nine strategic directions. The Australian Government

accepted the recommendations and PHN's have, in particular, commenced implementation of the stepped model of care.

What services does EMPHN provide and who does it serve?

14 EMPHN partners with health professionals, consumers and carers to:

(a) scope the gaps in the primary, mental health, AOD and suicide prevention sectors;

(b) identify emerging community needs; and

(c) commission services that address our community's needs.

15 EMPHN commissions a suite of services and works with a variety of health professionals including GPs, local hospital networks, and mental health services across the whole EMPHN catchment and services are targeted to people unable to access privately funded services. Some services, such as Quick Response Suicide Prevention service (**QRSPS**), are universally accessible by residents of all ages and socio-economic status, without a referral whilst other services have eligibility criteria of low incomes. All people accessing our services must work, live or study in the EMPHN catchment.

16 Examples of the services commissioned by EMPHN include:

(a) Mental health stepped care, which is an evidence based, clinically-staged system of care that includes a range of mental health interventions, from the least to the most intensive. This incorporates the QRSPS which consists of support (counselling sessions including strategies to manage anxiety, assess for suicide risk, develop a safety plan and endeavour to reduce the risk of suicide) for people who are at mild to moderate risk of suicide. This service is universally accessible to all residents without a GP referral. This service exists independently from the place-based trials;

(b) Psychosocial support services, which are available catchment wide and aim to address the needs of people who are not eligible for the National Disability Insurance Scheme. The services assist people to participate in their community and manage daily tasks;

(c) Psychiatric advice and consultation service, which provides specialist psychiatric consultation and advice to GPs and EMPHN-commissioned mental health and AOD service providers;

(d) Low intensity psychological services (Steps to Wellbeing), which provides wellbeing coaching support for people 16 years and over to help manage stress, anxiety and improve wellbeing;

(e) Youth mental health initiatives, including 'youth enhanced mental health services' which provide targeted support to young people with complex needs or emerging mental health issues; the 'enhancing mental health in secondary schools' initiative, which commenced in 2018 to help government schools support students with mental health issues; and youth suicide prevention activities, which I describe in more detail below;

(f) Older persons mental health services, including two pilot programs: a mental health in residential aged care facilities pilot; and a program which aims to support general practitioners and practice nurses better identify mental health challenges in older people, and support them to manage the care of older persons with mental health difficulties in the community;

(g) Mental health referral and access service, which is a navigation and referral service to assist consumers and service providers to access the appropriate service response; and

(h) Health Pathways, which is a clinical and service pathway tool to assist treating practitioners, specifically GPs, in delivering evidence based services. A suicide prevention health pathway has been recently developed by EMPHN and North West Melbourne PHN. This pathway has formed part of a number of pathways for mental health conditions and was developed independently of the trials.

Place-based suicide prevention trials

What are place-based suicide prevention trials? What place-based suicide prevention trials are run by EMPNH?

Place-based suicide prevention trials

17 A place-based approach recognises that people and places are inter-related, and that the places where people live and spend their time affect their health and wellbeing. A coordinated approach to suicide prevention means having well-planned prevention, intervention and crisis responses.

18 The purpose is to trial a systemic coordinated approach to suicide prevention. The initial work entails gathering information and building relationships in order to understand the local needs and local priorities, particularly in relation to people with lived experience of suicide (either suicidal ideation, attempting suicide or bereaved by suicide).

19 Based on this information, evidence informed initiatives are made available in the trial sites utilising the LifeSpan model as detailed further in the attachment marked '**AL-2**'. This includes:

(a) Training of GPs to identify and support people at risk of suicide;

(b) Community suicide prevention awareness programs e.g. Wesley Life Force training; and

(c) Wellbeing and health promotion activities with a focus on mental wellbeing.

EMPHN's place-based suicide prevention trials: Maroondah and Whittlesea

20 The EMPHN has been funded to run two place-based suicide prevention trials: one in Maroondah and one in Whittlesea. I describe the work involved in these trials below.

21 I understand that both the PHNs and the DHHS were involved in the site selection process before I commenced at the EMPHN. Each trial site was identified as having significant need due to suicide rates, and having regard to factors such as socio-economic status, population growth, self-reported high levels of psychological distress and rates of fair or poor health, Aboriginal and Torres Strait Islander population, and high proportion of people born overseas and speaking a language other than English. The identification of the sites also took into account local service and community capacity.

What are the objectives of those trials?

22 The objective of the place-based suicide prevention trials is to help local communities to prevent suicide through a coordinated place-based approach that delivers both universal and targeted interventions in communities across Victoria.

23 This is part of the Victorian Suicide Prevention Framework[1] which sets out five objectives, one of which is to help local communities to prevent suicide.

24 These trials operate alongside existing mental health services and suicide prevention services. The trials do not establish a new service, or duplicate existing services.

How are the two place-based suicide prevention trials funded?

25 The place-based trials were funded as part of the Victorian Government State budget (2016-17) which included $27 million to support two initiatives: the Hospital Outreach Post Suicidal Engagement trials (also known as the HOPE trials) and the place-based suicide prevention trials.

[1] Victorian Suicide Prevention Framework 2016-2025

26 In relation to the place-based suicide prevention trials, the Victorian State Government (via DHHS[2]) and Victorian PHNs are collaborating to trial place-based approaches to suicide prevention across twelve locations. DHHS has funded six locations; one in each of the PHN catchments. All the Victorian PHNs have agreed to contribute additional resources to deliver a second location in each PHN catchment. Each place-based trial site is delivered under the same operating model, including a common evaluation approach, planning and reporting (which I discuss in more detail below).

27 Within the EMPHN, Whittlesea, the State funded site, has been funded by DHHS for $1,363,000.00 over 4 years (2016-2020). The Federally funded site, Maroondah, has been funded by the PHN funds for suicide prevention amounting to $880,000.00 over 4 years (2016-2020). The EMPHN has pooled the funding for the two sites, so they share resources.

How many staff work on the place-based suicide prevention trials and what experience or qualifications do they have?

28 In the EMPHN, two staff are employed to work full time across the two place-based suicide prevention trials. The first staff member is a place-based co-ordinator. This is a senior program officer who has experience in community development, community and tertiary mental health and PHN program delivery. The second staff member is a project officer, who has administration and program support experience. These staff form part of a team within the Mental Health, AOD and suicide prevention Directorate and as such have line management and operational support within the organisation.

What do the place-based suicide prevention trials consist of?

29 EMPHN's place-based suicide prevention trials are being conducted in three phases with the work currently in phase three.

30 The place-based suicide prevention trials has used strategies informed by the Lifespan model developed by Black Dog Institute[3].

Phase One – establishing shared understanding and commitment to action

31 Phase one, conducted over a six month period, involved the team identifying and working with the community and local service system to establish a shared understanding of the purpose of the trials (as described above) and initial commitment to action to prevent suicide in the trial sites.

[2] Mental Wellbeing and Injury Prevention, Prevention and Population Health Branch, Health and Wellbeing Division

[3] LifeSpan is a recently developed, evidence-based approach to integrated suicide prevention and involves the implementation of nine evidence-based strategies from population level to the individual, implemented within a localised region, see the attachment marked "AL-4".

32 Through the series of three workshops and one on one consultations, the place-based team met with a broad range of stakeholders to try to understand what took people to the point of suicide, what supports were missing or not working, how the community can better support those at risk and what would be their proposed solutions for saving lives. Stakeholders included Victoria Police, local council, GPs, health services and people with lived experience: either people who have attempted to end their life, or people bereaved by suicide.

33 A range of themes were identified such as the importance of engaging with lived experience, addressing stigma, the importance of belonging and connection, trying to navigate the systems of support and the identification and support of those who may be at risk of suicide.

Phase two –raising awareness and consolidation of learnings

34 Phase Two, conducted over a period of five months involved a second series of workshops as well as training.

35 The workshops were attended by local stakeholders, as described above. The purpose of the workshops were to check in with the stakeholders, consolidate the information and learnings from the initial workshops in Phase One and to consider how people could contribute to the collective effort of saving lives in their local community. In those workshops, the top three things stakeholders said they wanted to see implemented were:

(a) training and education;

(b) clear and easy to navigate pathways to support; and

(c) a range of appropriate support services to meet the needs of a diverse community.

36 The training rolled out during Phase Two was delivered by a range of experienced providers and was intended to build the capacity of the community, the workforce and people with lived experience to be more skilled and confident when identifying and talking about suicide. Workforce attendees included GPs and GP practice staff, frontline workers such as health professionals, local council workers and community volunteers.

37 Additionally, concurrently with Phase Two, EMPHN has delivered activities in four key areas to raise awareness of mental health issues and to increase capacity to prevent suicide:

(a) **Capacity building** – suicide prevention training sessions as described previously for GPs, community members and health workers (for example, how they identify people in distress, how they should respond); training for people with lived experience to share their stories; establishing a working group of local stakeholders to address an increase in suicide in a Culturally and Linguistic Diverse (**CALD**) population;

(b) **Wellbeing programs** targeting 'at risk' populations:

(1) presentations on mental health and suicide prevention for sports clubs and men in business; and

(2) a pilot men's health program featuring health, wellbeing and information and exercise sessions, delivered in partnership with local stakeholders, for example Sons of the West in the North (Whittlesea), where the team contracted expert providers to raise awareness and impart skills and knowledge of how to look after one's physical and mental health;

(c) **Collective Impact Workshops** – as described in Phase One and Two which had the purpose of engaging with the local community to be part of the solution to reduce suicide and suicide attempts.

(d) **Collaborative Events** – to promote mental health and to assist navigate existing supports. For example, EMPHN collaborated with various local providers to deliver:

(1) In collaboration with Maroondah Council, EMPHN co-produced *The Ripple Effect* at Ringwood train station. This involved an arts and culture based approach to promoting local mental health services, capacity building training and engaging in conversations about help seeking to the general public;

(2) A series of Men's Health Lunches co-produced with local business and local council to target working men awareness and skill set for looking after their own wellbeing as well as their friends, community and workplace and how to have conversations with each other;

(3) Networks to Wellbeing event which was an event co-produced with the local youth service provider network in Whittlesea to target the school wellbeing co-ordinators to navigate mental health and suicide prevention referral pathways and resources. A version of this was also conducted in Maroondah in partnership with Maroondah Council;

38 Attached to this statement and marked "**AL-3**" are infographics highlighting the activities at each of the suicide prevention place-based trial sites between November 2017 and November 2018.

Phase three – Action

39 Phase Three involves consolidating localised actions identified in Phases One and Two to inform an action plan and what future services might include. In Phase Three, the trial will be delivered in parallel to the newly commissioned suicide prevention and postvention service as outlined later (in paragraph 69).

Specifically, what activities and services are provided through the place-based suicide prevention trials?

40 It is important to emphasise that the place-based suicide prevention trials do not involve providing any services. The role of the trial is to develop an understanding of the local community, and what the issues are – at a local level – which impact on risk of suicide. This is done through the work outlined above.

41 The trials have delivered activities consistent with the LifeSpan model to build capacity of local communities, raise awareness, responsible media, targeted training and health and well-being events (as detailed above and the infographics in the attachment marked 'AL-3'').

Please describe, by way of example, what occurs during a specified period at a trial site.

42 As noted above, the attachment marked "AL-3" highlights the activities at each of the suicide prevention place-based trial sites between November 2017 and November 2018.

43 By way of example, in the period from August to October 2018 the following occurred as part of the Whittlesea place-based suicide prevention trial:

(a) Facilitating partnership development and ongoing engagement.

(1) EPMHN co-ordinated a stakeholder working group for Sons of the West, a men's wellbeing program. The purpose of this working group was to trial if Sons of the West could be delivered utilising local stakeholders and resources both financially and in-kind to deliver; and

(2) EMPHN hosted a planning forum for the development of a youth suicide prevention communication protocol.

(b) Inclusion of lived experience and priority group.

(1) EMPHN worked with the City of Whittlesea Aboriginal Health and Wellbeing Network to hear what they needed for suicide prevention. There was a range of solutions discussed with the first action being for EMPHN to contract suicide prevention training which was culturally

appropriate. The training was delivered to the local network of Aboriginal and Torres Strait Islander service providers and come community members. Furthermore, the Network was connected through this work with the EMPHN Aboriginal engagement officer to ensure the Network was aware and engaged with the work of EMPHN work commissioning ATSI specific services.

(2) As one of our target groups was men, EMPHN contracted Western Bulldogs Community Foundation to deliver Sons of the West in the North (SOTWIN) in partnership with local stakeholders as described above. This program includes leadership of lived experience (past participants who have been through the program).

(3) EMPHN contracted a provider to deliver training to people with lived experience of suicide to build capacity to utilise their experience to effect change both in the community and the service system. An example of this is a young person who presented at the "Networks to Wellbeing" Forum for Whittlesea Youth Commitment as described earlier.

(c) Leadership and co-ordination of suicide prevention activities.

(1) The team facilitated, with a consultant, four whole of catchment workshops to consult with stakeholders to identify local suicide prevention needs and activities, across the spectrum from wellbeing to in crisis in order to inform the commissioning of a new suicide prevention and postvention service.

(2) Various types of training was contracted such as ASIST training on how to identify & support people in suicidal crisis (22 people attended) and Stop Male Suicide training (18 people attended).

Are the place-based suicide prevention trials targeted to specific cohorts? If so, which cohorts?

44 When the sites were initially selected, the decision was based on needs analysis using a range of data including, but not limited to, Australian Bureau of Statistics, DHHS data, Australian Institute of Health and Wellbeing. This combined data also provides indications of cohorts to focus on, due to their prevalence in the community. For example, City of Whittlesea has the fourth highest Aboriginal and Torres Strait Islander people and high proportions of people born overseas. In conjunction with this data, information from stakeholders (such as local council and Victoria Police) indicate cohorts at risk that may not be categorised in the Coroner's data.

45 Based on the data discussed at [44], the place-based trial in Whittlesea has focused on:

(a) Aboriginal people – through delivering culturally appropriate capacity building training, and EMPHN participation in the local Aboriginal network which has involved regular participation at network meetings and focus groups;

(b) young people – identifying the service system supporting young people, and highlighting gaps. With local stakeholders, EMPHN has begun the work of developing the North East Melbourne Youth Suicide Prevention Communication Protocol;

(c) the needs of certain CALD communities (this group would not have been identified if not for the place-based nature of the work); and

(d) older men – through the Sons of the North in the West program.

46 Based on the data discussed at [44], the place-based trial in Maroondah has targeted:

(a) men – aged over 25;

(b) young people – adopting the same approach as in Whittlesea; and

(c) sporting clubs – through the mental health and wellbeing sports and life training.

Are there guidelines for what the place-based suicide prevention trials can include?

47 DHHS developed operating model parameters in relation to the suicide prevention place-based trials (the **Guidelines**).

48 The Guidelines require the trials to focus on capacity building and enhancing system effectiveness, rather than service expansion or new services. The Guidelines provide that the trials may include:

(a) training of general practitioners to assess depression and other mental illnesses, and support people at risk of suicide; suicide prevention training for frontline staff, including police, ambulance and other first responders; and gatekeeper training for people likely to come into contact with at-risk individuals;

(b) awareness raising through school-based peer support and mental health literacy programs and community suicide prevention awareness programs;

(c) responsible suicide reporting by media; and

(d) reducing access to lethal means of suicide.

49 The Guidelines give the following further guidance on the content of the place-based trials:

(a) Allocate local suicide prevention resources (funding) based on community needs and objectives, ensuring the right strategies and initiatives are targeting the right settings and populations to maximise the benefits for the local population. An example of this in practice is the community appetite for Sons of the West in the North.

(b) Implement a whole of system approach to suicide prevention that is responsive to the needs and concerns of the local population and the local context.

(c) Bring together local partnerships with a common agenda, strengthen mutually reinforcing activities and work together to deliver a collective impact.

(d) The trial will actively involve local organisations and groups in decision-making, bringing together and being inclusive of organisations and groups that have the potential to impact the health and wellbeing of the community in the places where people live, learn, work and play.

(e) Integration and coordination across local community efforts, as well as integration and coordination with the State-wide suicide prevention effort.

Progress and evaluation of the place-based suicide prevention trials

What stage have the two place-based suicide prevention trials reached?

50 In terms of the stage of the trials, EMPHN is currently in Phase Three, which is the action phase. EMPHN has considered how to best adapt the learnings from the place-based trial into the suicide prevention work that EMPHN commissions more broadly. The commissioning of the new model is outside the scope of the trials themselves but was a strategic decision by EMPHN to utilise the learnings and opportunities from the place-based trials to scale up our work in suicide prevention to the whole of catchment whilst still continuing the focus on the trial sites. The model that EMPHN has commissioned is discussed below.

Is any data being recorded in relation to the place-based suicide prevention trials? If so, what data and how is it being analysed? What will the data be used for?

51 EMPHN records and gathers data for each of the Maroondah and Whittlesea place-based suicide prevention trials. The following data is provided to DHHS for the purpose of evaluating the model of the place-based trials:

(a) Activity and outcome data for example qualitative and quantitative feedback about how training has ensured the skills to identify suicidality which is being routinely collected and reported quarterly by the place-based suicide prevention trials sites;

(b) An annual Most Significant Change process with each site and at a state-wide level;

(c) Regular online surveys of all site partners;

(d) Annual in-depth interviews with each site's Key Influencers and central DHHS; and

(e) Site suicide and self-harm audits drawn from Ambulance Victoria, the Coroner's Court of Victoria, Turning Point and the Victorian Injury Surveillance Unit.

How are the place-based suicide prevention trials being evaluated and assessed?

Reporting obligations

52 As outlined above, EMPHN is required to report data to DHHS as part of trials. EMPHN provides quarterly reports to a governance group within DHHS. I am a member of the governance group.

53 The governance group oversees the place-based trials across the State, and examines emerging issues. For example, at one point it was difficult to recruit appropriate staff. The governance group is also responsible for reviewing the evaluation (discussed further below).

State wide evaluation

54 The Victorian Government has established an external evaluation. I have contributed to the development of the evaluation framework.

55 DHHS has commissioned the Sax Institute to deliver an Evaluation Framework. The Framework details a multi-phase approach for evaluating the place-based suicide prevention trials. The Sax Institute has also been commissioned to evaluate the Establishment phase within the framework.

56 The proposed timeline for the evaluation of the Establishment phase (Phase One) ends in July 2021. As this is too soon to determine any impact on community-level resilience and suicide outcomes, a second summative evaluation is proposed, drawing exclusively on existing and ongoing data sources such as Coroner's data, Victorian Population Health Survey data and Ambulance attendance data.

57 Each phase of the evaluation will use a variety of methods to focus on answering slightly different key evaluation questions (using data gathered from a variety of sources) including:

(a) Place-based suicide prevention trials sites' quarterly progress reports and annual reports – including detailed contextual and implementation data;

(b) Site-conducted evaluations of capacity building and resilience promoting training events;

(c) Most Significant Change evaluation processes;

(d) Bi-annual surveys of everyone involved with the place-based suicide prevention trials in each site;

(e) Annual interviews with the Key Influencers within each site;

(f) Annual surveys of relevant professional stakeholders within each site; and

(g) A variety of existing datasets, including the Victorian Population Health Survey and routinely-collected suicide-related data.

58 The evaluators have completed the Evaluation Framework and are now finalising the draft of the Establishment phase evaluation report. This the first of three phases as listed below:

(a) Establishment phase of the trial. Exploring how well the trials are developing partner relationships and their place-based approach, perceptions about governance structures and overall operating model, and any early learnings.

(b) Formative evaluation phase where the initiative key elements are in place and partners are implementing agreed upon strategies and activities.

(c) Summative phase exploring the trials' contribution to improving a range of system, individual and community outcomes.

Local evaluation: EMPHN

59 The EMPHN gathers the data for the state wide evaluation. In addition, EMPHN will evaluate the services commissioned based on the place-based trials.

What has been the outcome of any evaluations of the place-based suicide prevention trials that have occurred to date?

60 The state wide evaluation team commissioned by DHHS has just drafted the establishment phase report, and no formal evaluations have been finalised. As such, it is too early to determine any outcomes in relation to reducing suicide or suicide attempts.

How many community members have participated in activities or services provided through the place-based suicide prevention trials?

61 The trials are not designed to deliver to activities or services a defined number of community members, but to understand how best to support the community to reduce

suicide. However, EMPHN has gathered numbers of participants and types of activity (see the attachment marked 'AL-3').

What have the trials concluded so far about what can be done to reduce the suicide rates in the trial sites, and how it should be done?

62 Again, until the trials are fully evaluated it would be premature to draw final conclusions. However, over the course of the trails the EMPHN has drawn a number of observations and learnings as described below.

EMPHN's response to the place-based suicide prevention trials

Key learnings

63 It must be remembered that there is no single cause of suicide, and no simple solution to prevent it.

64 The place-based trials have given a deeper, more nuanced understanding of suicide and suicidality in the EMPHN catchment which has informed the development and commissioning of a more responsive and accessible service and activities that help the community to be part of the solution. The feedback and involvement of those people with lived experience highlights the importance of community connections and gives a voice to those who have been mostly silent and disconnected in their grief and pain.

65 We heard how the system continually fails people; both those feeling suicidal and those who are bereaved.

66 The key learnings from the place-based suicide prevention trials thus far are:

(a) There is a level of disconnection of the service support system in Maroondah and Whittlesea. There is a lack of awareness and understanding of what services and supports are available, both amongst individuals and practitioners. This highlighted to EMPHN the need to build clearer pathways and service connection for people in the community who may be at risk or impacted by suicide.

(b) The power of community. The local communities of Maroondah and Whittlesea want to be part of the solution for reducing suicide. The relationships built through place-based approach has enabled local stakeholders to know where to take suicide issues when they arise in the community and, by working together, they are more confident and willing to address a challenging and stigmatized issue.

(c) Targeted marketing and building relationships has enabled EMPHN to reach broadly into the community and not just the health sector where suicide prevention has traditionally been. This has meant EMPHN has engaged with particular cohorts – such as men and specific CALD communities – who may not have previously engaged.

(d) People with lived experience have been empowered to be heard, and have learned how to best use their voice to effect change.

(e) Suicide prevention should form part of a response for clinical services that ensures risk assessment and escalation to more intensive services is available.

(f) Intervening early in mental illness and getting the right supports and access to them is imperative.

(g) We heard from the community that reducing stigma and discrimination was important by being able to have the skills to talk about mental illness and suicide.

(h) When people leave clinical mental health services and are identified as being at risk of suicide there needs to be a safety plan in place. It must also be made clear to consumers and their families where they can go when their condition escalates, and they need to be responded to with dignity and respect.

(i) The funding of mental health services can be fragmented. EMPHN is primarily funded through the Commonwealth Department of Health, however, the place-based trials have enabled PHNs to bring together Commonwealth and State funding at a local level through a co-commissioning approach brokered through the Victorian PHN Alliance and DHHS. The place-based trials present a good

opportunity to identify need and existing gaps and how we can commission suitable services to address community needs

67 Attached to this statement and marked '**AL-5**' is an example of how community members have benefited by the place-based approach.

What are the limitations of the place-based suicide prevention trials?

68 There are three main limitations of the place-based suicide prevention trials:

(a) First, it is challenging to measure tangible outcomes in suicide prevention, due to the complexities surrounding why people choose to end their lives.

(b) A second limitation is the time frames. This limitation arises in three ways:

(1) First, it takes time to develop and build genuine relationships and trust with stakeholders; this means that EMPHN cannot see tangible impacts immediately.

(2) Second, there is a time lag in accessing Coroner's suicide data. It is very difficult to measure the effectiveness of suicide prevention interventions because EPMHN does not receive data from the Coroner on the number of suicides in an LGA until at least one year after the death. This means there is a lag between the intervention, and the ability to assess the effectiveness of the intervention (at least using the measure of suicide rate).

(3) Third, addressing stigma and trying to reach out to the whole community are slow processes.

EMPHN's strategy in light of the place-based suicide prevention trials

69 Based on the knowledge gained from the place-based suicide prevention trials, EMPHN has commissioned and implemented a new innovative model which consolidates both Commonwealth and State funds to co-commission a whole of catchment suite of suicide prevention and postvention service and activities. To be clear, this did not form part of place-based trials but is based on the learnings from the trials. As such the trials have played a crucial role in shaping those services.

70 The new service model, LifeConnect, delivers a whole of EMPHN catchment suite of suicide prevention and postvention service and activities, which includes but is not limited to:

(a) wellbeing activities;

(b) programs and activities that target 'at risk' groups;

(c) media and communications to promote help seeking and reduce stigma;

(d) development of formal protocols and integrated care pathways with tertiary health, EMPHN Mental Health Stepped Care providers, GPs and other primary and community health services;

(e) community capacity building and training;

(f) workforce development building capacity to identify and manage suicide risk; and

(g) direct support postvention services.

71 In addition to the learnings of the place-based trials, the specifications for the model were informed by two theoretical models which are set out in the attachments marked 'AL-2' and 'AL-5', namely:

(a) the LifeSpan Model (Black Dog, 2017). The use of these two models is based on an extensive review of relevant suicide prevention literature and evidence-based practice (marked '**AL-2**'); and

(b) the Integrated Wellbeing-Motivation-Action Model (Mendoza, Ozols, Donovan & Cross, 2018) (marked '**AL-5**');

In your opinion, does more need to be done to try and significantly reduce the suicide rate in the EMPHN? If so, what else should be done?

72 I believe more needs to be done in the areas we have identified below. EMPHN will work on these as part of our EMPHN Regional Integrated Mental Health, AOD and Suicide prevention plan, however they cannot be done in isolation or without funding:

(a) Provide an alternative option to the emergency department for people experiencing a suicidal crisis after hours, for example, the Safe Haven Café model.

(b) Transitions of care - to improve pathways and transitions for planned and unplanned care in the community.

(c) Earlier detection and response for people at risk of suicide attending at a general practice.

(d) Linking parts of the mental health system – between acute and community based services and ensuring there is good continuity of care for people involved in mental health services.

(e) Clinical Governance – a robust system that includes skilled professionals operating within their scope of practice, evidenced based practice, clinical review, clinical risk management and adequate reporting, data collection and monitoring system.

73 Furthermore, it is imperative that suicide prevention involves:

(a) working with CALD, Aboriginal and Torres Strait Islander people and other 'at risk' groups to specifically target suicide prevention to mobilise the community to be part of the change;

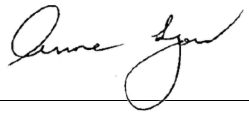
(b) using a systems and place-based approach;

(c) workforce development: skill and educate clinicians and GPs in triage and risk assessment;

(d) early intervention;

(e) clinical interventions that can help to mitigate risk – where suicide prevention forms part of the model care delivered by practitioners; and

(f) the data gathered by the Coroner's prevention unit is timely in its dissemination to system planners and include information about CALD status.

sign here ► 

print name Anne Lyon

date 22 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AL-1

This is the attachment marked '**AL-1**' referred to in the witness statement of Anne Lyon dated 22 July 2019.

ANNE LYON

Career Summary

An experienced senior executive with diverse experiences in the health, education, government and community sectors. An innovative leader with a history of implementing effective change management across diverse settings including the public sector, governance, and operational management. Extensive experience in working with multiple stakeholders to influence, negotiate and achieve agreed outcomes.

RECENT PROFESSIONAL HISTORY

JUNE 2017-

CURRENT EXECUTIVE DIRECTOR, MENTAL HEALTH & AOD

- Lead the development of innovative mental health services and implement a stepped care model consistent with national policy directions.
- Provide strategic direction on integrated service planning and development across the EMPHN catchment.
- Oversee the commissioning and procurement of primary mental health, alcohol and other drugs and Aboriginal mental health services.
- Lead development and implementation of strategy and business plans, accountability mechanisms, clinical governance and stakeholder engagement.
- Ensure program delivery is undertaken in accordance with Commonwealth funding and contractual requirements.
- Develop effective relationships with key stakeholders – government, community members and provider sector.

MARCH 2017- Acting Executive Director, Primary Health Services

July 2017

- Provide leadership and management of the Primary Health Services directorate.
- Oversee the commissioning and procurement of primary mental health, alcohol and other Drugs, after hours, Aboriginal Health and General Practice development services.
- Provide direction on procurement and contract management development for commissioned services.
- Ensure program delivery is undertaken in accordance with Commonwealth funding and contractual requirements.

May 2015- General Manager, Primary Health Services, South Eastern
July 2016 Melbourne PHN

Responsibilities & Achievements

- Managed the successful and seamless transition of Medicare Local programs and services to South Eastern Melbourne PHN (SEMPHN)

- Oversight and development of Annual Workplans and reporting frameworks for key programs in the establishment phase of the SEMPHN.
- Established the Primary Health Services Directorate ensuring the delivery of a range of primary mental health and drug and alcohol services.
- Developed strategic and productive high level partnerships with major stakeholders within the region including GP's, Local Hospital Networks and a broad range of public and private health care providers. ☐
- Provided high level expertise to the establishment of SEMPHN ensuring strong planning processes are established for the efficient and effective delivery of activities in accordance with Department of Health contractual obligations and funding agreements. ☐
- Played a lead role in the implementation of the primary health care reform agenda and contributed significantly to the development and implementation of business plans, strategic directions, accountability mechanisms, clinical governance leadership, client/family centered programs and community engagement. ☐
- Oversight and management catchment wide population health needs assessment

Feb 2013 – May 2015 **General Manager, Sector Development, Bayside Medicare Local**

Responsibilities

The role provided leadership and facilitated:

- Overall management of key stakeholder relationships and partnerships
- Population health planning and needs assessment for the Bayside catchment
- An understanding of primary health care service system delivery and capacity
- Service development through key projects with a focus on health equity
- Acting CEO as required.

Mar 2012 - Dec 2012 **General Manager Organisational Support & Development**
Inner South Community Health Service
Role transitioned to a Business/Service Development role
Establishment of Multidisciplinary General Practice Service
Project Manager building redevelopment

Sept 2011 - Feb 2012 **Acting Chief Executive Officer**
Inner South Community Health Service

Inner South Community Health Service is a $22 million community based organisation providing allied health, chronic disease management, dental, counselling, health promotion, mental health, drug & alcohol, child & family services within the City of Port Phillip and City of Stonnington.

Responsibilities & Achievements:

- Provided leadership and oversight of the organisation and support to the Board of Directors until the recruitment of a new CEO finalised.

- Liaison, collaboration and negotiation with key stakeholders including Commonwealth, State and Local Governments and key industry groups.
- Undertook role of Company Secretary
- Chair of ISEPICH PCP
- Appointed to the Transition Board of the Bayside Medicare Local
- Member Victorian Healthcare Population Health Approaches to Planning Advisory Group

Jan 2010 – Sept 2011 **General Manager Organisational Support & Development**
Inner South Community Health Service
Parental Leave replacement

Responsibilities:
Overall management and leadership of organisational support and infrastructure services which includes: Finance, Administration ,Information Technology, Strategy, Policy & Advocacy, Governance Support, Human Resources, Quality portfolio, Occupational Health & Safety, Risk Management, Contracts, Asset and Site Management

Acting CEO responsibilities as required

Key Achievements
- Reviewed Governance structures and established Audit & Risk Board Committee recruiting external expertise
- Refinement of board & management financial reporting
- Improvement to capital planning & introduction of Capital Reserves policy
- Key role in development of new five year strategic plan
- Successful funding applications at Commonwealth & State levels for: infrastructure, asset management, management training (approx $450K)
- Oversight of key IT & Telephony infrastructure upgrades
- Introduction of Joint Chair Health Equity initiative including contractual arrangements and oversight of development of 3 year research strategy and plan

Sept 2008 – Jan 2010 **Consultancy/Project Management**
Undertook a range of consultancy and project work for community based services and Department of Human Services which included:

Key Projects
- Development and subsequent presentation of Clinical Leadership in Community Health Report for Victorian Healthcare Association, Community Health Clinical Governance Steering Committee.
- Review of Service Delivery Hume Early Childhood Intervention Services
- Review of Governance Structure – rural Community Health Service
- EMR Care Coordination for People with Complex Needs Initiative – delivery of 4 facilitated workshops and development of Care Coordination Framework for inter agency working.

2005- 2008 **Chief Executive Officer**
Knox Community Health Service (KCHS)

Knox Community Health Service is an $8.5 million dollar community based organisation providing allied health, chronic disease management, dental, counselling, health promotion and family support services to residents within the City of Knox.

Providing leadership to the organisation and working with the Board to implement the strategic plan.

Key Achievements:

- Increased annual turnover from $3.75 million (2004-05) to $8.9 million (2007-08). This includes a 70% plus growth in the funding base ($7.3 million) and $1.6 million growth in contracted services. (staffing complement increased from 45 EFT to 80 EFT).
- Led development of Strategic Planning process with Board of Management – Strategic Plan 2006-2009 in place with clearly defined key performance indicators reflected in annual operating plan.
- Integrated the School Dental and Community Dental Programs through a pilot program which provided the foundation for statewide implementation of government policy on integrated dental services.
- Lead agency for re-development of Dental Services in the outer east of Melbourne as a result of integrated area based planning process for Care in Your Community (key government policy direction). Secured additional resources for the sub-region.
- Led contract negotiations ($1.6 mil) on behalf of Eastern Region Community Health Services with Eastern Health for delivery of HARP services and subsequent contract management responsibility for those services.
- Systems development to support service delivery:
  - Reviewed current business operating systems and implemented new financial, human resource management and payroll systems to support increased operational growth
  - Implemented new client management systems in community health and oral health service areas.
- Developed and implemented new service programs such as Chronic Disease management, a program targeted at reducing obesity in children and Dose Adjusted For Normal Eating (DAFNE) for Diabetes - first community health service to deliver this program.
- Introduced quality improvement initiatives including service reviews, evaluation of service delivery and a Clinical Governance program to strengthen and support safe, quality service delivery for clients. Three year external accreditation achieved.
- Increase in funding base through innovative projects from Commonwealth, State Governments & Trust grants:
  - Challenging the Obesity of Kids (COOK) – Education & prevention program for parents & schools on health eating
  - Health Services Innovation Council – Integrated approach to chronic disease management incorporating oral health services

- Family Violence Community Accord Project (VicHealth)
- Commonwealth funding for Mental Health & Drug & Alcohol services (three funding submissions in excess of $1.5 million over three years)

Memberships:
Vice Chair, Care in Your Community Network Planning Group – Outer East Trial
Chair, Service Coordination Committee Primary Care Partnership
Member, Victorian Healthcare Association, Community Health Victoria Clinical Governance Steering Committee
Stakeholder Reference Group – Integration of Oral Health Services (DHSV committee)
Chair, OEPCP Service Coordination Committee

2002–2005 Director
Home and Community Services
Mecwa Community Care

Mecwa is a $24 million not for profit organisation providing disability, residential and community aged care services across metropolitan Melbourne. Reporting to the CEO, general management responsibilities for community aged care and disability services across metropolitan Melbourne. Management and responsibility for a staff of 450 employees including a management team of six direct reports.

Key Achievements:
- Developed and reviewed business plans for home and community programs and Mecwa Redicare, aligned with organisational strategic directions and incorporating key performance indicators
- Undertook service redevelopment and restructuring, including establishing partnerships with local government and integration of programs to improve services for clients
- Provided effective budgetary and financial management of $13 million operating budget, including achieving 7.7% growth and improved profitability in Mecwa Redicare and 10% budget surplus in home and community care programs
- Led negotiation of contractual arrangements with the Department of Human Services, achieving 15% increase in funding for home and community care services
- Membership of two executive committees for Primary Care Partnerships, providing guidance on the implementation of the primary care reform agenda and advocating on behalf of the sector with government
- Redeveloped policy and promotional documentation to support improved client focus and business growth
- Ensured services were consistent with regulatory and accreditation frameworks, achieving home and community care accreditation and ISO certification across multiple service types and sites
- Human resource management:
  - Developed a recruitment and retention strategy, achieving reduction in staff turnover from 29% to 17% in eighteen months

- Introduced an Enterprise Bargaining Agreement for program staff to ensure equitable remuneration and stability of workforce in a highly casualised working environment
- Ensured compliance with occupational health and safety regulatory requirements and contractual arrangements and to promote a safe and healthy workplace for all employees

2002 **Acting Director**
Policy and Program Development
Disability Services Division
Department of Human Services

2002 **Manager**
Community Strengthening and Support
Disability Services Division
Department of Human Services

2001 **Manager**
Service Planning Resource Group
Policy & Strategic Projects Division
Department of Human Services

2000–2001 **Project Manager**
State Disability Plan
Disability Services Division
Department of Human Services

Key Achievements:

- Led development of the Victorian Government's disability policy—the *Victorian State Disability Plan 2002–2012* and the *Implementation Plan 2002–2005*—a leading edge and internationally acclaimed disability policy set within a rights and citizenship framework
- Developed and implemented an extensive and multifaceted communications and consultation process, establishing a benchmark consultation and policy development process within the Victorian Government providing a basis for development of the Plan.
- Achieved whole-of-government commitment to initiatives, through negotiation with State Government Departments, being mindful of political sensitivities across portfolio areas
- Negotiated passage of documentation through Cabinet processes, including negotiation with key Government Departments and provision of support to the Minister for Community Services

EDUCATION AND QUALIFICATIONS

- Master of Public Policy and Management
- Monash Mt Eliza Business School

- Bachelor of Education
- Latrobe University
- Diploma of Nursing Education (Midwifery)
- Lincoln Institute of Health Sciences

RECENT PROFESSIONAL DEVELOPMENT

Bridges out of Poverty October 2014
Intensive Bioethics Course – Monash University – December 2010
Australian Institute of Company Directors Course – May 2010
Victorian Health Board Governance Program - Advanced Training March 2009
Capacity Building for Boards & Committees
Group Facilitation Workshop - 2009
Senior Management Program
Department of Human Services
Risk Management
Ruth Bailey & Associates
Media Skills – Maximising the Media – Workshop (June 2007)

PUBLICATIONS

BROWN, A, MASON V, LYON A: "STRENGTHENING CLINICAL GOVERNANCE IN COMMUNITY HEALTH", AUSTRALIAN JOURNAL OF PRIMARY HEALTH – VOL. 14, NO. 2 AUGUST 2008.

MEMBERSHIPS

AUSTRALIAN INSTITUTE OF COMPANY DIRECTORS

VOLUNTEER & GOVERNANCE EXPERIENCE

2006 – 2014	Board member, Women's Legal Service Victoria Elected Chair in 2012
2007 – 2009	Board member, DASSI Governance & Risk committee
2002–2006	Board Member, DASSI (Disability Attendant Support Service Inc.), including Chair Fundraising committee
2004	Acting Chair, DASSI Provided leadership to the DASSI Board during a period of significant change, achieving a budget surplus and improved governance structure, including increased representation of people with disabilities on the Board.
2008	Board Member, Dental Health Services Victoria Board Sub-Committees – Quality, Population Health, Human Research and Ethics
2009 -2011	Board Member, Dental Health Service Victoria Board Sub-Committees – Quality, Population Health, Human Research and Ethics (Chair), Board Research Advisory Panel (Chair)
2012 2013	Board Member, Bayside Medicare Local Chair, Governance, Audit & Risk Sub-committee

Royal Commission into Victoria's Mental Health System

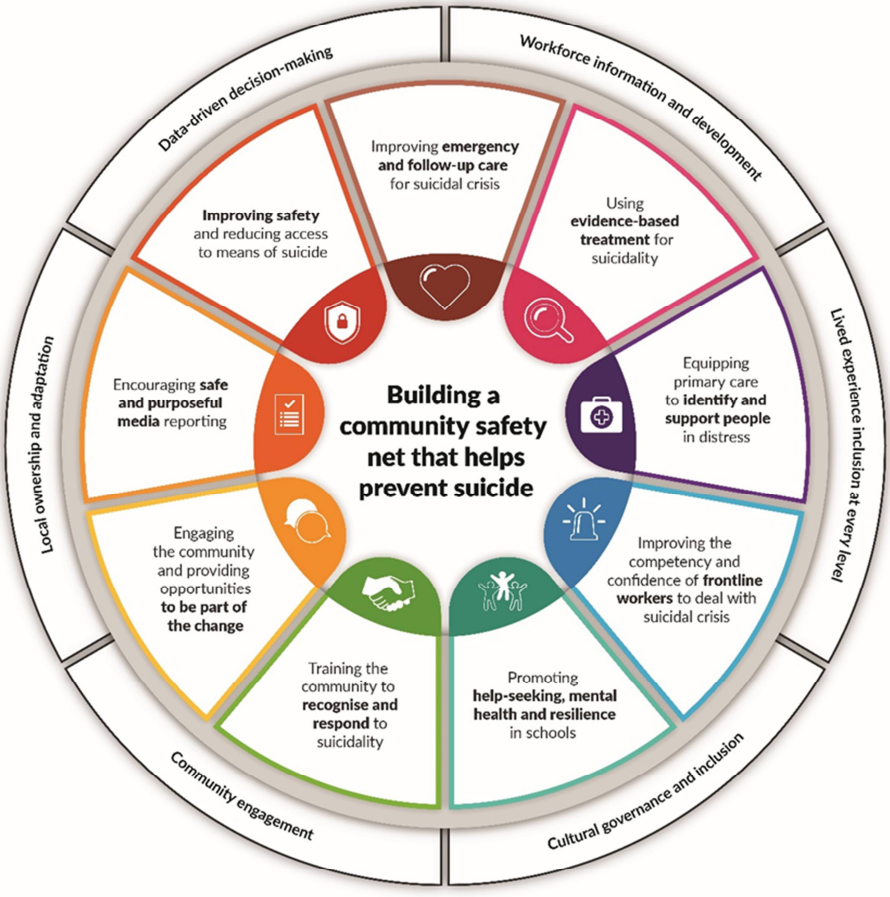
ATTACHMENT AL-2

This is the attachment marked '**AL-2**' referred to in the witness statement of Anne Lyon dated 22 July 2019.

LifeSpan: an evidence-based, integrated approach to suicide prevention (2017). Black Dog Institute, Sydney

Developed by the Black Dog Institute, the LifeSpan model (Figure 4 below) is an evidence based approach to integrated suicide prevention. The approach combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community (BlackDog, 2017).

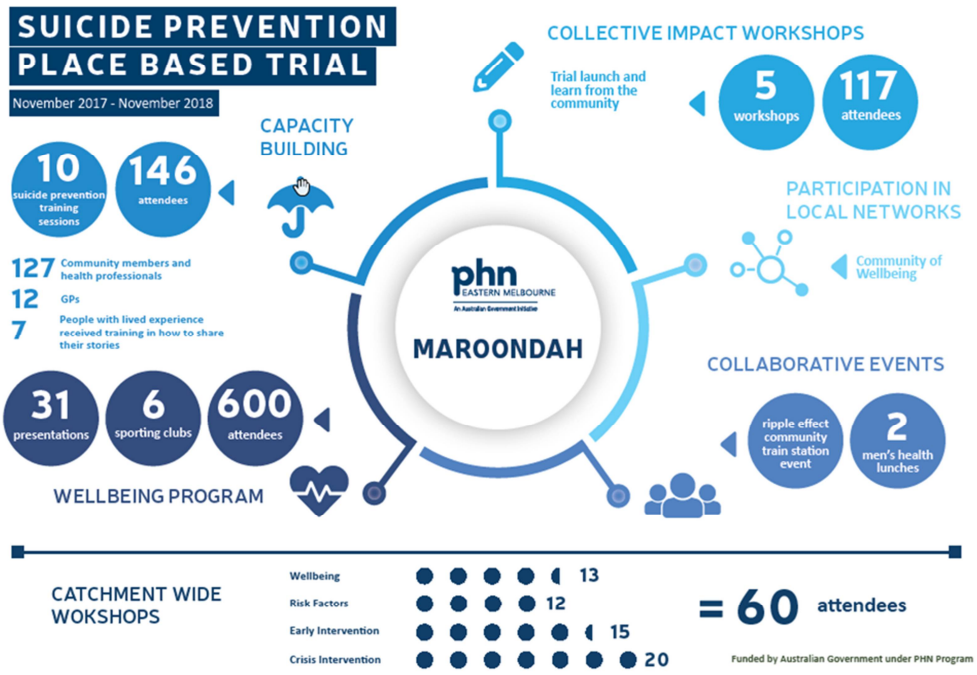
"LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis" (BlackDog, 2017).

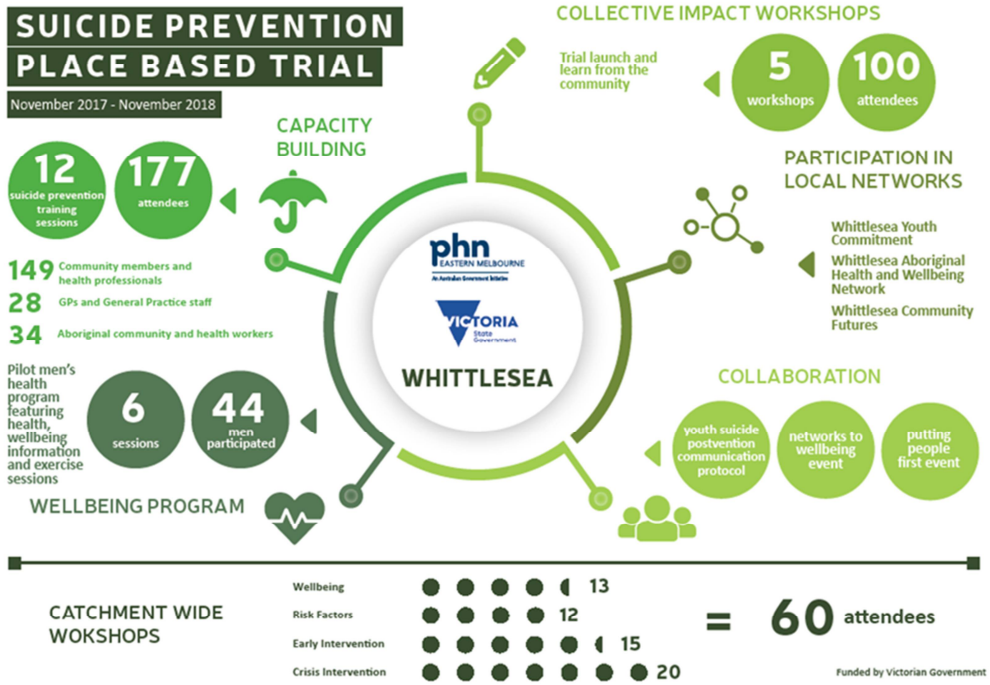


Royal Commission into Victoria's Mental Health System

ATTACHMENT AL-3

This is the attachment marked '**AL-3**' referred to in the witness statement of Anne Lyon dated 22 July 2019.





Royal Commission into
Victoria's Mental Health System

ATTACHMENT AL-4

This is the attachment marked '**AL-4**' referred to in the witness statement of Anne Lyon dated 22 July 2019.

Most Significant Change Story – Maroondah

The situation BEFORE:	Disparate people with lived experience having no contact with each other.
What happened:	Some people with lived experience attended Collective Impact workshops held in the site and we invited them to attend some lived experience training.
The situation AFTER:	Since the training, they have formed their own support group and been involved in many PBSPT activities, including a Roses in the Ocean conference and featuring in our site PBSPT video. They meet regularly and keep formulating new ways to contribute towards suicide prevention, including working with Lifeline and advising the mental health royal commission about their media releases.
Why so significant?	We now have a local group who greatly value the support they get from each other, with each member flourishing personally … it's made a genuine difference to those people's lives.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AL-5

This is the attachment marked '**AL-5**' referred to in the witness statement of Anne Lyon dated 22 July 2019.

The Integrated Wellbeing-Motivation-Action Model

1 The Integrated Wellbeing-Motivation-Action model (**IWMA**), illustrated in the diagram below, represents the next generation of suicidal behaviour models (Mendoza et al., 2018). The IWMA model is based on the Ideation to Action Framework and Three-Step Theory of Suicide (Klonsky & May, 2015), and the Integrated Motivational-Volitional Model of Suicidal Behaviour (O'Connor, 2011). It attempts to more clearly distinguish between the development of suicidal thinking and the factors that govern behavioural enactment.

2 The IWMA model accounts for developments in understanding the personal and contextual journey from wellbeing to suicidal behaviour, and the evidence on systems approaches to suicide prevention. The IWMA model adds a wellbeing dimension, and incorporates the theory and evidence on developing wellbeing, social connection and resilience. It provides a robust model for planning, implementing and evaluating suicide prevention activities.

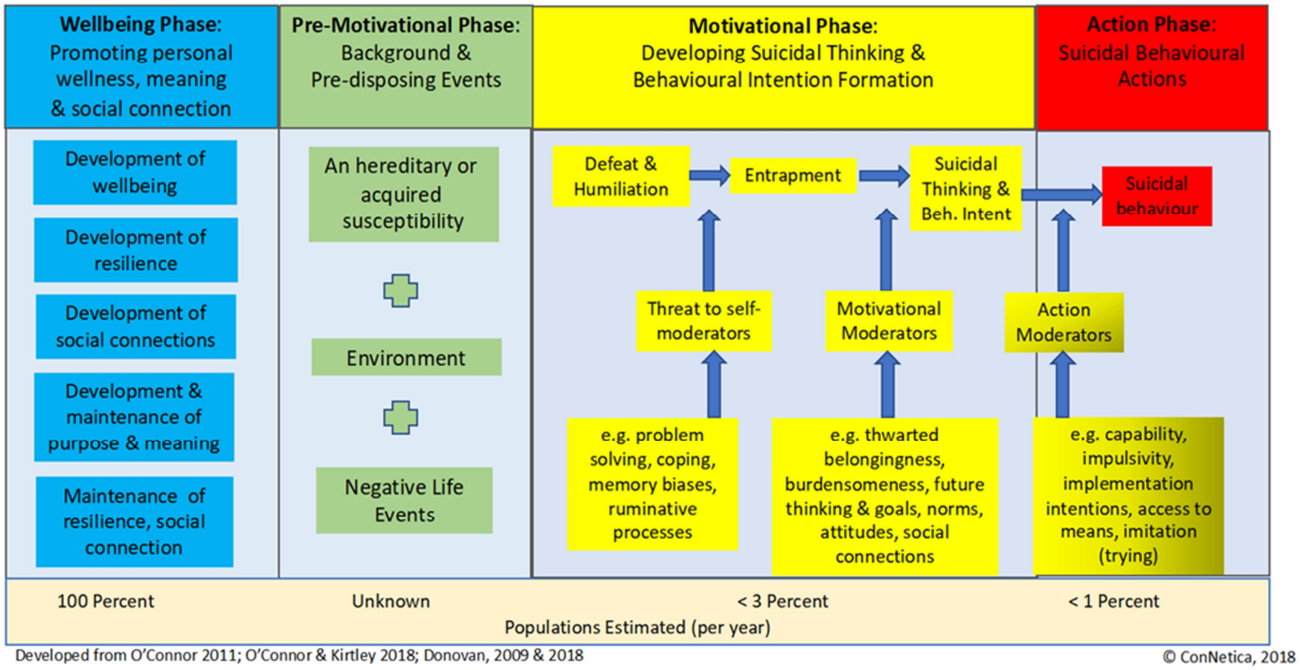
3 According to the IWMA model, it is important to develop services and interventions which target:

(a) primary prevention - development of resilience, self-efficacy, meaning and purpose and social connectedness (the wellbeing phase)

(b) secondary prevention - addressing the background or predisposing factors and predisposing negative events through eliminating or ameliorating their presence and/or impact (the pre-motivational phase)

(c) early intervention – to respond to the emergence of suicidal thinking and behavioural intention formulation (the motivational phase)

(d) crisis intervention – to respond and intervene at the intention–behaviour gap (the action or volitional phases) (Mendoza et al., 2018).



(Mendoza et al., 2018)