Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF LUCINDA (LUCY) BROGDEN AM

I, Lucinda (Lucy) Frances Brogden AM, Chair of the National Mental Health Commission, of Level 29, 126 Phillip Street, Sydney, in the State of New South Wales, say as follows:

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.

I make this statement in my capacity as Chair of the National Mental Health Commission.

Background and qualifications

1 I hold a Bachelor's Degree in Commerce and Accounting from the University of New South Wales. I also hold Graduate and Postgraduate Diplomas in Psychology, and a Master's Degree in Organisational Psychology, from Macquarie University.

2 I have more than 25 years' commercial experience with companies including Macquarie Group and Ernst & Young, working in accounting, finance, and organisational psychology. Specifically, I have worked in trusted advisory roles with some of Australia's leading CEOs, Managing Partners, Ministers and Chairs.

3 In addition to my role as Chair of the NMHC, I serve as Chair of the Mentally Healthy Workplace Alliance and the Australian Advisory Group for Suicide Prevention; a Patron for Partners in Depression and Lifeline Northern Beaches; and a Friend of Carers NSW. I am also the Founder and Patron of Sydney Women's Fund; a Director of Be Kind Sydney; a Governor of Queenwood School; and an Ambassador for Kookaburra Kids.

Current role

4 The Chair and Commissioners of the Advisory Board of the NMHC provide leadership and advice that informs the work and strategic direction of the Commission. As Chair, I am responsible for leading meetings of the Advisory Board; providing leadership and promote cohesive, effective teamwork by Commissioners; and reporting to the Minister for Health on the outcomes of Advisory Board meetings. I am also an official spokesperson for the NMHC.

Contributing lives

5 The term 'contributing life' first appeared in the NMHC's 2012 National Report card on mental health and suicide prevention.[1] It is defined as a life enriched with close connections to family and friends; good health and wellbeing to allow those connections to be enjoyed; having something to do each day that provides meaning and purpose – whether it be a job, supporting others or volunteering; and a home to live in, free from financial stress and uncertainty.

6 The NMHC's *Contributing Life Framework* acknowledges the ambition that people with a mental illness can lead contributing lives and expect the same rights, opportunities, and physical and mental health outcomes as the wider community. A contributing life is one where an individual is thriving, not just surviving; receives effective support, care and treatment; has something meaningful to do and something to look forward to; has connections with family, friends, culture and community; and is feeling safe, stable and secure.

7 The *Contributing Life Framework* is framed around a whole-of-person, whole-of-system, whole-of-life framework to mental health and wellbeing.[2] This means we consider people across the lifespan – from pre-birth to old age. The framework provides a five-pronged approach to mental health and wellbeing. The components of the framework provide a structure for mental health that can be utilised for all ages

8 The *Framework* recognises that a fulfilling life requires more than just access to health care services. Some of the most powerful root causes of health inequalities are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life. These conditions are collectively referred to as the social determinants of health. Social determinants can strengthen or undermine the health of individuals and communities.

9 The *Contributing Life Framework* aligns closely with actions to address social determinants of health identified by the World Health Organization (WHO). The WHO social determinants approach to improving mental health advocates for a collaborative approach and emphasises that reducing health inequalities is most effectively achieved when health equity is prioritised in all policies and across all sectors. The WHO also

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[1] National Mental Health Commission (2012). *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/9ab983bc-d825-41cf-ba04-a3d49e8d4257/2012-National-Report-Card-on-Mental-Health-and-Suicide-Prevention.pdf

[2] National Mental Health Commission (2012). *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/9ab983bc-d825-41cf-ba04-a3d49e8d4257/2012-National-Report-Card-on-Mental-Health-and-Suicide-Prevention.pdf

proposes that policies from non-health portfolios should explicitly state their likely contribution to health.[3]

10 The NMHC recognises the role of the community in the recovery and wellbeing of individuals, and hence the need to ensure communities are supported to offer activities that enhance social cohesion and encourage individuals to connect. Recognising the role of community aligns with the NMHC's *Contributing Life Framework,* where an individual is supported to live a contributing life across health and other domains. In addition to distinguishing between the community-based care system (within mental health) and community services, there is also a need to distinguish between community services and community, including different roles in relation to retaining and reclaiming a contributing life.

11 The greatest benefit comes from the interaction between these three different but aligned components: where the mental health system has a clear policy and funding framework for services; where services are provided in the community, by the community, to meet community needs; and where the community is supported to meaningfully engage with individuals and build social connectedness.

12 It is essential to adequately address non-health portfolios and social determinants of mental health through a *Contributing Life Framework*, and to ensure mental health promotion is effective across the government portfolios, including social policy and services, employment, education, housing and justice. Alongside this work, it is also necessary to ensure that any new government policies and programs be assessed for their potential impact on the mental health and wellbeing of the whole community.

13 It is important to note that, in order to sustainably reform mental health approaches across governments and government portfolios, there is a need to develop a mental health and suicide prevention framework that has a clear focus on shared mental health outcomes, prioritised through incentives, underpinned by evaluation, and with the authority to hold portfolios accountable. These will be some of the areas addressed in the NMHC's work on Vision 2030, which seeks to establish a long-term blueprint for a successful, connected, and well-functioning mental health and suicide prevention system meeting the needs of all Australians.

Role of the National Mental Health Commission

14 The NMHC's vision is that all people in Australia are enabled to lead contributing lives in socially and economically thriving communities.

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[3] National Mental Health Commission (2019). *Monitoring mental health and suicide prevention reform: National Report 2019*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/f7af1cdb-d767-4e22-8e46-de09b654072f/2019-national-report.pdf

15 To achieve this, the NMHC aims to:

- ensure mental health and wellbeing is a national priority
- increase accountability and transparency through credible and useful public reporting and advice
- provide leadership and information that helps to empower consumers and carers
- collaborate with others to influence decision-making, set goals and transform systems and supports to improve people's lives.

16 There are many factors internal and external to the organisation which may impact on the NMHC's ability to achieve its objectives. These include:

- collaboration between key stakeholders to implement changes
- the capacity of the Australian, State and Territory governments to invest and redirect funding into areas which add the greatest value
- government policy to support and influence reform, including changes to current direction.

17 Factors that assist the NMHC to achieve its objectives include the following:

- There is substantial stakeholder alignment with reform directions
- The NMHC has an established reputation for working collaboratively with all key stakeholders, including consumers and carers
- There is broad support for our independent advisory function to government and the community.

18 As an independent executive agency, the NMHC operates at an arms-length from the departments and agencies that manage funding and services. This supports the NMHC to provide independent advice and reports to governments and the community on mental health outcomes and reform.

19 In the draft report of its inquiry into mental health,[4] the Productivity Commission made a number of recommendations regarding the role and function of the NMHC. One strength of the proposed changes is building greater robustness in the evaluation culture of the mental health and suicide prevention system.

20 The Productivity Commission's draft report calls for the NMHC to lead the evaluation approach, through a consultative coordination function, including program-level

[4] Productivity Commission (2019). *Mental Health*: *Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

evaluations. The NMHC supports such an evaluation function and notes that it would be based on an evaluation at a systems level (which would include program evaluation as necessary to evaluate the effectiveness and efficiency of the system).

21 Consumers and carers access multiple programs and services, which is why outcomes cannot be directly attributed to a single program or service. Systems-level outcomes are derived by looking at the collective impact across programs and services. For a country as geographically spread and regionally diverse as Australia, these variations are critical to effective monitoring, evaluation and reporting at a national level.

22 There is also a need to identify the mechanisms to support the Productivity Commission's recommendations for the NMHC. Becoming a statutory authority would enhance the monitoring, evaluation and reporting role of the NMHC by:

- legislating the relationships and responsibilities for conducting system evaluation and improvement
- documenting independence and expert status
- increasing the ability to hold others accountable.

23 In any distribution of system functions, there needs to be clarity of roles and responsibilities. For example, it is important that the responsibility for system policy delivery and coordination be separated from the responsibility to monitor, evaluate and report on system policy outcomes, so that independence and integrity can be achieved for both functions. This is possible to achieve this within a single organisation (that provides separate functions), or multiple entities.

24 The capability and capacity of entities should be carefully considered when distributing system management functions across multiple entities.

Mentally Healthy Workplaces

25 Australia's work health and safety legislation requires employers to provide a workplace that is psychologically safe. The interventions that are needed to create mentally healthy workplaces are not conceptually complex, in that they go to the essentials of good business management. Implementation is reliant on an organisation having the capability to recognise and address psychosocial health risks, and make and monitor changes.

26 Essentially, sustaining a mentally healthy workplace in organisations regardless of their size involves:

- good job and work design
- promoting and facilitating early help seeking and intervention

- building a positive and safe work culture
- enhancing personal and organisational resilience
- supporting recovery
- increasing the awareness of mental illness and reducing stigma.[5]

27 As can be seen from the list above, the entire organisation needs to be involved as the issues span workplace health and safety, human resources, management, leadership, workforce behaviour, workplace representation and learning and development.

28 The NMHC has a history of action to facilitate mentally healthy workplaces. It takes a lead in this area nationally, and as Chair of the Mentally Healthy Workplace Alliance (see below) and the NMHC, I am personally involved in several national collaborative committees and working groups including the Collaborative Partnership, the Corporate Mental Health Alliance Supporters Forum and the Expert Advisory Group to the National Suicide Prevention Adviser.

29 In 2013, the NMHC established a collaborative industry alliance, the Mentally Healthy Workplace Alliance. This Alliance comprises a mix of government, industry and non-government members who together advocate for stronger action in this area. Members include the Australian Chamber of Commerce and Industry, the Australian Faculty of Occupational and Environmental Medicine, the Australian Industry Group, the Australian Psychological Society, Australian Council of Trade Unions, Beyond Blue, the Black Dog Institute, the Business Council of Australia, Comcare, the Council of Small Business of Australia, Mental Health Australia, Safe Work Australia, SANE Australia and Super Friend.

30 The Alliance helped secure Australian Government funding for the National Workplace Initiative in the 2019–20 budget. Through this initiative and with the leadership of the Alliance, the NMHC will support employers, industries, small businesses and sole traders to create mentally healthy workplaces that enable workers to achieve their best possible mental wellbeing, and that attract skilled staff, encourage innovation and boost productivity. It will establish a nationally consistent approach to mental health in the workplace, and will provide businesses with assistance and guidance on how to build work environments that promote good mental health, reduce mental illness, and help people recover when they are unwell.

31 The aim is to reduce confusion about how to create mentally healthy work environments and support implementation. This initiative will give businesses resources that work and a clear, step-by-step process for taking action. The content will be evidence-based,

[5] The strength of the evidence supporting different workplace interventions varies, however. Attached to this statement and marked 'LB-**Error! Main Document Only.**' is a copy of the outcomes of a literature review conducted for the Mentally Healthy Workplace Alliance in 2014, which indicates that many forms of intervention are supported to some extent.

bring together existing material and provide implementation support. The total cost of the National Workplace Initiative from 2019–20 to 2022–23 is $11.5 million.

Families and carers

32 The NMHC supports the Royal Commission's findings, as set out in its Interim Report, that the mental health system is reliant on the contribution and commitment of families and carers to support their loved ones living with mental illness; yet the system itself is placing ever-growing pressure on families and carers without providing the necessary support. The Interim Report clearly identifies the challenge that although the need to engage families and carers, and the value in doing so, is recognised by law and regulation, the experience of families and carers has shown that this engagement often does not occur.[6]

33 The Royal Commission should consider the Productivity Commission's draft recommendations to enhance supports and family-focused and carer-inclusive service delivery for carers. Changes proposed by the Productivity Commission include amendments to the eligibility criteria for Carer Payment (adult) and Carer Allowance (adult) to increase the flexibility of the criteria, taking into consideration the specific nature of the mental illness and the importance of increased flexibility for mental health carers in the workplace (draft recommendation 13.1).[7]

34 The Productivity Commission's draft report also recommended that the NMHC commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory government mental health services (draft recommendation 10.1).[8] The NMHC acknowledges that the intent of the recommendation is to improve outcomes for children of parents with mental illness and would support the design and evaluation of the trial, regardless of how the trial was funded.

35 Mental health and suicide prevention services should provide family-focused and carer-inclusive care as routine practice. To inform this practice, the NMHC recommended in its first submission to the Productivity Commission's inquiry into mental health that State and Territory governments consider implementing the Mental Health Carer Experience

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[6] Armytage, P. et al (2019). *Royal Commission into Victoria's Mental Health System: Interim Report.* State of Victoria.
https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4215/8104/8017/Interim_Report__FINAL_.pdf
[7] Productivity Commission (2019). *Mental Health*: *Draft Report.* Canberra: Productivity Commission.
https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf
[8] Productivity Commission (2019). *Mental Health*: *Draft Report.* Canberra: Productivity Commission.
https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

Survey as a routine service measure, and that findings from data such as these surveys be made public.[9]

36 It is a service-wide responsibility to ensure family-focused and carer-inclusive mental health service delivery and the NMHC has proposed that the Productivity Commission consider alternative ways to achieve these aims. For example, Lived Experience Australia (previously the Private Mental Health Consumer Carer Network) has developed a practical guide for working with carers of people with a mental illness, accompanied by online training, an online library, an app and an implementation plan, which may prove informative.

37 Poor mental health of one family member can affect other family members, and family relationship-related issues can impact on all family members' mental health.[10] The Medical Benefit Scheme (MBS) Review Taskforce is currently considering how MBS-subsidised services can be better aligned with contemporary clinical evidence and practice to improve health outcomes. The Mental Health Reference Group (MHRG) appointed by the Taskforce released its report in February 2019. The report includes a proposal (Recommendation 7) to enable family and carers to access therapy. The NMHC supports the proposed changes that recognise the important role of family and carers in consumers' recovery journeys, as partners in the ongoing therapeutic relationship, alongside consumers and practitioners. This recommendation is also consistent with the Productivity Commission's draft recommendation 13.3.

38 Monitoring how well consumer and carer needs are being met is a key component of monitoring the performance of the mental health system. Ongoing monitoring and reporting also contributes to service improvements and improved future outcomes for consumers and carers.

39 The NMHC has been given responsibility for delivering an annual report on the implementation progress of the Fifth National Mental Health and Suicide Prevention Implementation Plan actions and performance against the identified indicators. To recognise the importance of carers leading a meaningful and contributing life, the Fifth Plan includes the proportion of mental health carers in employment as one of its performance indicators.

40 To supplement this report, the NMHC conducts annual national surveys to capture the experiences of consumers and carers, and determine whether the actions currently

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[9] National Mental Health Commission (2019). *Submission to the Productivity Commission on the social and economic benefits of improving mental health.* https://www.mentalhealthcommission.gov.au/getmedia/ff47283d-d5ef-47b6-8e56-e5e7cfd7438a/Submission-to-the-Productivity-Commission-Inquiry-into-the-Social-and-Economic-Benefits-of-Improving-Mental-Health.pdf

[10] National Mental Health Commission (2019). *Submission to the Medicare Benefits Schedule Review Taskforce* [unpublished].

being implemented under the Fifth Plan are translating into tangible improvements in how consumers and carers experience mental health care. The first of these surveys was conducted in 2019, and the second survey has recently closed.

41 The issues reported by consumers and carers in the 2019 survey – such as the availability and adequacy of mental health services, the availability and cultural appropriateness of services for Aboriginal and Torres Strait Islander communities, and experiences of stigma and discrimination – reinforce the intended direction of priority areas and subsequent actions under the Fifth Plan. As implementation of the Fifth Plan progresses incrementally over the coming years, the NMHC expects to see changes in Australia's mental health system. The NMHC will continue to survey and report on the experiences of consumers and carers to ensure that these changes result in genuine improvements for people with mental illness, their families and carers.

Lived experience workforce

42 The Royal Commission's Interim Report provides a comprehensive analysis of the emergence and value of the lived experience workforce and challenges it faces, which I will not duplicate in this statement. The NMHC supports the Royal Commission's recommendations to establish the first residential mental health service designed and delivered by people with lived experience; and to implement a co-produced program to expand the lived experience workforce and workplace supports for its practice.

43 My witness statement will focus on three areas that the NMHC is currently working on: the development of the National Peer Workforce Development Guidelines; supporting the establishment of a member-based organisation for the peer workforce in Australia; and addressing the lived experience workforce in the National Mental Health Workforce Strategy.

44 The need to develop a national professional peer workforce and encourage support structures and professional development for the peer workforce is a key priority for the NMHC. Mental health peer Work has been an area of focus for the NMHC since our establishment in 2012. The development and promotion of the mental health peer workforce has been recommended as part of our 2012 and 2013 National Report Cards and the 2014 *Contributing Lives, Thriving Communities* report.

45 The NMHC's monitoring and reporting have highlighted the challenges faced by the peer workforce include stigma and discrimination, lack of resources to meet demand, lack of peer supervision and professional development opportunities, and inappropriate and complex award structures and remuneration. There is also a lack of accurate data to monitor and evaluate the growth and effectiveness of the workforce and, unlike other mental health professions, peer workers have no professional peak representative

organisation. The peer workforce requires support from governments to ensure a safe working environment free from stigma and discrimination, with adequate support structures, to guarantee the workforce grows and retention rates improve.[11]

46 Under the Fifth Plan, the NMHC is leading the development of Peer Workforce Development Guidelines by 2021. This project will support the peer workforce through the development of formalised guidance for governments, employers and the peer workforce about support structures that are required to sustain and grow the workforce. Although local and regional peer workforce frameworks exist, the development of national guidelines will ensure consistency across Australia. National guidelines will also be a step towards professionalisation of the peer workforce.

47 The NMHC established a Steering Committee to oversee the work to develop the Guidelines through an open expression of interest process. Steering Committee members come from across the mental health sector and across jurisdictions, including a majority of the committee being peer workers with experience across the public, private and community-managed sectors.

48 In collaboration with RMIT University and a team headed by Dr Louise Byrne, the NMHC has conducted a national consultation process to inform the initial draft of the Guidelines. The consultations took place between August 2019 March 2020 and included conference workshops, focus groups and a national online survey.

49 The expansion of lived experience workers into service delivery roles can be better supported through greater clarity and consistency. The NMHC is currently addressing some of these matters as part of the Guidelines project, which will create role delineations for peer workers that provide opportunities for meaningful contact with consumers and carers and grassroots-based advocacy; and identify effective anti-stigma interventions with the health workforce.

50 The Guidelines will address the options for recognition of prior learning, both for entry to the peer workforce and for entry of peer workers to other careers in the mental health workforce. However, there is also a need to enhance professional development opportunities and career pathways within the peer workforce, such as through increasing the availability of senior and leadership roles for peer workers with the appropriate qualifications and experience. There is also potential to further support the development of peer worker roles outside traditional health care settings (such as in digital and phone-based services), and to consider career pathways involving broader lived experience roles.

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[11] National Mental Health Commission (2018). *Monitoring mental health and suicide prevention reform: National Report 2018*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/cf4296f2-a5df-431d-844b-428ecd05b018/Monitoring-Mental-Health-and-Suicide-Prevention-Reform-National-Report-2018.pdf

51 In September 2019, the NMHC published findings of a feasibility study conducted by Lived Experience Australia (formerly the Private Mental Health Consumer Carer Network) into the establishment of a member-based organisation for the peer workforce. The project sought to examine where the sector is now and what it sees as the need for peer worker support, and a model for such an organisation. The consultations and research identified that the establishment of a peer workforce organisation in Australia would be a significant catalyst for change and a major contributor to the mental health reform agenda.[12]

52 The NMHC will provide further advice to the Australian Government on the steps involved for establishing and funding this organisation. The Productivity Commission's draft recommendation 11.4 also supports work to strengthen the peer workforce by establishing a national representational/regulatory body for the peer workforce

53 The peer workforce is growing significantly, and is increasingly valued across government and the community sector for contributing to better outcomes for consumers and carers. Despite significant growth, the working conditions for the peer workforce are lagging and its growth is not consistent across jurisdictions, the State and Territory mental health services, the community managed sector and the private sector. The NMHC considers that the work of the Royal Commission and at a national level by the Productivity Commission will drive prioritisation of the research needed to establish and consolidate the evidence base on the value of peer work. Peer workers also need to be involved in policy and service design.

54 Alongside the peer workforce, the Aboriginal mental health workforce and rural and remote workforce are developing as important elements within the overall mental health workforce and are likely to grow in scope and significance. Current support structures for these workforces are inadequate and a focus on increasing access to appropriate supervision (such as peer supervision for peer workers), career progression and workplaces free from discrimination is required. These issues will be considered by the National Mental Health Workforce Strategy (see below).

The Mental Health Workforce

55 The Royal Commission has addressed a number of issues pertaining to the mental health workforce in Victoria in its draft report. Many of these issues are experienced nationally and are areas of reform also highlighted in the Productivity Commission's

[12] Private Mental Health Consumer Carer Network (2019). *Towards Professionalisation Final Report: A project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/2cae09c7-9d6d-43c8-bade-382c0261b38f/Towards-Professionalisation-final-report

draft report. The NMHC aims to take a very broad approach the mental health workforce and includes the suicide prevention workforce in our deliberations and work.

56 Mental health workforce challenges and mitigation strategies will be addressed in the National Mental Health Workforce Strategy (the Workforce Strategy) currently being developed jointly by the Australian Government Department of Health and the NMHC. The key features of a system-level workforce strategy to meet current and future demands on mental health services will be explored by the National Mental Health Workforce Strategy Taskforce (the Taskforce) and subject matter experts.

57 I understand that, to date, the Taskforce has agreed on a number of priority areas to further progress and inform the development of the Workforce Strategy. The Workforce Strategy will need to connect with workforce planning already occurring in states and territories as well as actions under the Fifth National Mental Health and Suicide Prevention Plan, specifically, the development of the Peer Workforce Development Guidelines and the development of a Workforce Development Program.

58 In its 2019 National Report, the NMHC recommended the Workforce Strategy be released with an implementation plan.[13] Additionally, the Productivity Commission in its draft report recommended the Workforce Strategy set targets to attract and retain workers, and establish a system to monitor and report progress in achieving the targets.[14] The development of an implementation plan with performance indicators will be critical to the evaluation and monitoring of the Workforce Strategy and its effectiveness in meeting current and future demands on mental health services.

Commissioning

59 The Productivity Commission's draft report outlines structural changes to drive greater regional mental health planning and commissioning.[15] The NMHC supports funding changes that allow mental health and suicide prevention services to be commissioned regionally, where local needs are better understood. The NMHC strongly supports regional approaches to commissioning but believes this needs to recognise and leverage the federated model of health care funding and care delivery.

60 A 'rebuild' model where funding is moved from the Australian Government to State and Territory governments for regional commissioning has some challenges:

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[13] National Mental Health Commission (2019). *Monitoring mental health and suicide prevention reform: National Report 2019*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/f7af1cdb-d767-4e22-8e46-de09b654072f/2019-national-report.pdf

[14] Productivity Commission (2019). *Mental Health*: *Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

[15] Productivity Commission (2019). *Mental Health*: *Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

- It does not recognise that State and Territory governments, who are traditionally responsible for commissioning and implementing tertiary care, may not be best placed to understand or commission primary care services.

- It does not provide for adequate monitoring of the return on investment of Australian Government funds.

- It creates another 'layer' between funders, service providers and consumers and carers.

61 State and Commonwealth governments must put mechanisms in place to ensure services are commissioned to meet the needs of the community and are integrated seamlessly from the consumer and carer perspective. This means commissioning processes need to ensure that decisions are strategically aligned and coordinated. The existing structures of Primary Health Networks (PHN) and Local Hospital Networks (LHN) already embedded within communities can be utilised to enable this alignment and coordination in commissioning.

62 Vision 2030 proposes utilising governance structures that facilitate a national framework for the delivery of diverse local solutions in a way that is transparent, consistent and measurable. These governance structures for a national system under which regional commissioning can meet the needs of the local community include:

- agreements and policy
- leadership – coordination and oversight
- investment
- standards and specifications
- community design and delivery

63 These structures can enable governments to drive an integrated and well-functioning system. In addition, focusing on ongoing mental wellness outcomes and impact measurement, monitoring and evaluation will continue to drive quality care.

64 The NMHC believes that system reform for a redesigned mental health system needs to include consideration of the capacity and capability of the system to respond to future changes to service demand. This is articulated in Vision 2030 as a mental health and wellbeing system where needs-matched support is available to every Australian regardless of location.

65 As the NMHC noted in its submission to the Productivity Commission,[16] the current funding model is imbalanced, with greater weight given to the primary and acute care services. Future commissioning strategies need to strengthen the approach to funding services across the stepped care model and include early intervention and community-based services. This will ensure the funding model supports not only people experiencing mental illnesses but also the prevention of mental illness and promotion of wellbeing and recovery.

66 There is an identified need to ensure people receive appropriate care that matches need and preferences for access. To inform commissioning of services, it is important to ascertain the correct level of service to meet population needs, and to do so using formal analysis of robust data. Needs-based service/workforce planning is essential to establish the resourcing required at local and population level.

67 It is also important for commissioning approaches to consider how consumers and carers are going to be directly involved in all aspects of system planning, design, monitoring and evaluation. This means consideration needs to be given to how commissioning approaches can be co-designed and implemented with authentic engagement of consumers and carers.

68 To ensure authentic collaboration, the NMHC supports an organisational structure/s for the collective voices of consumers and carers to be supported by all governments. However, the NMHC recognises that there is a contested view across the sector as to whether a structural peak body is for consumers and/or carers. In addition, outcomes that are important for all system participants, including consumers and carers, should be based around the *Contributing Life Framework*.

69 Commissioning approaches should also recognise the need for case coordination and support for those with complex needs to ensure individual needs are met and care is provided in an integrated and continuous manner, acknowledging the episodic nature of mental ill-health.

State and Commonwealth relations and national reform

70 There is a division of roles and responsibilities for legislation, policy, funding, and service delivery across the mental health system in Australia. These roles and responsibilities are divided among the Australian Government, State and Territory governments, PHNs, LHNs, and the private and non-government sectors. Beyond the

[16] National Mental Health Commission (2019). *Submission to the Productivity Commission on the social and economic benefits of improving mental health.* https://www.mentalhealthcommission.gov.au/getmedia/ff47283d-d5ef-47b6-8e56-e5e7cfd7438a/Submission-to-the-Productivity-Commission-Inquiry-into-the-Social-and-Economic-Benefits-of-Improving-Mental-Health.pdf

mental health system, many other government portfolio areas and community services play a critical role in addressing the social determinants of health, in areas such as employment, education, housing, justice and social security. In addition, the families and carers of people with mental illness contribute to the mental health and suicide prevention system by supporting consumers to recover and live in the community.

71 Many of these roles and responsibilities overlap with or impact each other. This can create uncertainty and complexity for service providers, as well as for the consumers and carers navigating the system.

72 The diversity of key stakeholders responsible for planning and delivering services presents challenges in collecting and sharing data. This has resulted in knowledge gaps throughout the sector, one of which is data on 'unmet need'. Although planning tools have been developed to assist with the appropriate provision of services to local populations, additional data is needed to understand how services can address the needs of the population that are not currently being met.

73 The Productivity Commission's draft report noted that concerns were raised about the lack of clarity in Commonwealth and State and Territory roles, including that the Commonwealth's direct funding of local service providers has been without proper consultation, local planning and engagement and has created greater uncertainty for people with lived experience and providers, and even more confusing pathways for people with lived experience.[17]

74 The Productivity Commission further noted that there is a plethora of psychological supports across Australia, funded by both the Australian and jurisdictional governments. This has resulted in a complex web of different streams.

75 Many providers receive funding from both the Australian Government and State and Territory governments. While this reduces risk for organisations if funding agreements change with one government, submissions to the Productivity Commission report that multiple funding channels have diminished the coverage and quality of psychosocial supports and have led to excessive administrative burden, lack of coordination and cooperation between providers and government, and difficulties navigating the system for consumers.

76 A range of psychosocial support options are also available under the National Disability Insurance Scheme (NDIS) for those deemed eligible, which is jointly funded by the Australian, State and Territory governments.

[17] Productivity Commission (2019). *Mental Health*: *Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

77 However, the NMHC is concerned about the psychosocial support options for those who are found ineligible to access the scheme, or who choose not to test their eligibility or drop out of the process. It is currently unclear what support services will be available for this group, particularly when both Commonwealth and State and Territory funding for mental health services is being redirected to the NDIS.[18]

78 The Commission supports the COAG commitment to ensuring that all existing clients of Commonwealth funded mental health services who do not meet the NDIS eligibility, will be provided continuity of support, consistent with their current arrangements. The Commission also supports the announcement of the National Psychosocial Support measure to assist people with psychosocial disability who are not eligible for the NDIS, and not currently in any existing Australian Government program.

79 Regardless of who is responsible for funding services, mechanisms must be put in place to ensure that services are commissioned to meet the needs of the community and are integrated seamlessly from the consumer and carer perspective. This means greater analysis and emphasis needs to be placed on reforming the commissioning processes to ensure decisions are strategically aligned, coordinated, and duly diligent.

80 As a legacy of traditional and historical approaches to service delivery, the funding model is imbalanced, with greater weight given to the primary and acute care services. Future funding models need to strengthen the approach to funding services across the stepped care model and include early intervention and community-based services. This will ensure the funding model supports not only people experiencing mental illnesses but also the prevention of mental illness and promotion of wellbeing and recovery.

81 There is currently a fragmented approach to dealing with social determinants and their influence on mental health, with responsibility for mental health-related policies and programs dispersed across Australian Government and State and Territory portfolios. Mental health and social determinants policies should not be created in silos. A whole-of-government (including State and Territory governments) approach to addressing the social determinants of mental health would:

- provide consistency in policy across jurisdictions, reducing inequality in service provision
- give greater clarity of roles and responsibilities
- minimise duplication and allow best practice to be shared across all levels of government

[18] Productivity Commission (2019). *Review of the National Disability Agreement Study Report.* Canberra: Productivity Commission: https://www.pc.gov.au/inquiries/completed/disability-agreement/report

- allow mental health policies in portfolios relating to social determinants to be created in collaboration with different agencies and following reciprocal consideration of relevant policies
- make it easier to consult with consumers and carers, community organisations and other relevant non-government stakeholders, to allow their views to be considered in the development of new policies
- allow effective independent monitoring and reporting to be conducted on policy outcomes, with results of these processes used to refine or improve the policy and inform future policies.[19]

sign here ▶ 

print name Lucinda Brogden

date 11 May 2020

[19] National Mental Health Commission (2019). *Monitoring mental health and suicide prevention reform: National Report 2019*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/f7af1cdb-d767-4e22-8e46-de09b654072f/2019-national-report.pdf

Royal Commission into Victoria's Mental Health System

ATTACHMENT LB-1

This is the attachment marked 'LB-1' referred to in the witness statement of Lucinda (Lucy) Brogden AM dated 11 May 2020.

From: **Developing a mentally healthy workplace: A review of the literature.** A report for the National Mental Health Commission and the Mentally Healthy Workplace Alliance.
Prepared by: Dr Samuel B Harvey et al. November 2014

Research informed workplace mental health strategies and strength of evidence	**STRENGTH OF EVIDENCE**
WORKPLACE STRATEGY	
Designing and managing work to minimise harm	
• Encouraging flexible work	✓✓
• Encouraging employee participation	✓✓
• Reducing other known risk factors and ensuring the physical work environment is safe	✓
Promoting protective factors at an organisational level to maximise resilience	
• Psychosocial safety climate	✓
• Developing anti-bullying policies	✓
• Enhancing organisational justice	✓
• Promoting team based interventions	✓
• Providing manager and leadership training	✓✓
• Managing change effectively	✓
Enhancing personal resilience	
• CBT-based stress management/resilience training	✓✓
• Resilience training for high risk occupations	✓✓
• Single session resilience training	?
• Coaching and mentoring	✓✓
• Worksite physical activity programs	✓✓
Promoting and facilitating early help-seeking	
• Well-being checks or health screening	✓
• Routine psychological debriefing following a traumatic event	X
• Peer support schemes	✓
• Workplace counselling	✓
Supporting workers recovery from mental illness and during stressful life events	
• Supervisor support and training	✓
• Partial sickness absence	✓
• Return-to-work programs	✓✓
• Work focused exposure therapy	✓✓
• Individual placement and support for severe mental illness	✓✓✓
Increasing awareness of mental illness and reducing stigma	
• Mental health education and first aid	✓
• Development of a mental health policy	?

Levels of evidence and definition

✓✓✓ **Good body of evidence to guide practice.** High or moderate quality systematic reviews/meta-analyses demonstrating consistent results from multiple RCTs and

	consistent evidence from a body of well-designed observational studies
✓✓	**Some research evidence to guide practice.** High or moderate quality systematic reviews/meta-analyses demonstrating consistent evidence from non-RCT intervention trials or less consistent evidence from RCTs on top of consistent evidence from a body of well-designed observational studies
✓	**Limited research evidence.** Mixed or inconclusive evidence from research literature. Interventions supported by good observational evidence but high quality interventional studies lacking
?	**Research evidence unknown.** Inconclusive research evidence at present, but some theoretical support
X	**Good research evidence supporting that the strategy is not effective**. Conclusive evidence from good quality research and multiple RCTs that this approach is not effective and should not be implemented in the workplace