



Innovative approaches to mental health offering advice and practical solutions for:

- ✓ Project management and consultancy on local, state and national levels
- ✓ Staff Development Training
- ✓ Conference Speakers & Sector Leadership

Productivity Commission Draft Report into Mental Health

DRAFT RECOMENDATION 14.3 / INFORMATION REQUEST 14.1 – VOLUME ONE

Page 73/74 – IPS model to sustain employment of people with a mental illness whilst maintain collaborative links with community mental health services.

- When the star rating system first came in to play within the employment sector it sent shock waves into the system with many agencies having to shut down due to the transition. Due to the star rating system, employment agencies have an ongoing fear of losing their funding and subsequently having to cease operations. Because of this, it would be better for an IPS consultant to be directly employed by a community mental health service to ensure consistency and longevity of the program model. My suggestion would be that the Community Development Officer (or similar position) be utilised in the hiring and supervision at the local level for this particular role. I would imagine the IPS worker being completely independent of a particular employment provider but could link in with any number of providers that each of their consumers are affiliated with.
- I believe the way such a role would be funded through a fixed salary with the rate being higher than an average employment consultant rate given that it is a more specialised and tailored role. This is also in line with the increased complexity of need and acuity in the community mental health service caseloads within a sophisticated multi-disciplinary team.

DRAFT RECOMMENDATON 16.7 – VOLUME ONE

Page 81 – non-legal advocacy services

- Whilst there may be currently different advocacy bodies in different states or different platforms for such services, consumers and families need to be made explicitly aware of what they are and what they involve so that can utilise this service
- In WA for example, I am still encountering consumers and families that do not know that we have a Mental Health Advocacy Service in which they can utilise
- I suggest that consumers and families are made aware of this within emergency departments and inpatient facilities within the first 24 hours of being within a facility, with visual material also displayed throughout facilities – to ensure that facilities comply with this it can be factored in to auditing processes so that there is a higher level of accountability.



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DRAFT RECOMMENDATION 17.3 – VOLUME ONE

Page 84 – social and emotional learning programs in the education system

- Whilst I applaud the draft report findings of acknowledging programs in schools as a great source of early intervention and prevention at the local level, my concern is that we may be placing undue pressure on an individual that may not be suited in that role. School psychologists, chaplains or counsellors would be an ideal choice however these can also be under resourced and sparse between schools. My question is why aren't we able to utilise what we have but create better targets of involvement within schools? We also need to be aware that emotional health and wellbeing is an area of specialisation and requires a role that can be flexible in its approach whilst also making sure supports and services are involved early to reduce lifelong problems associated with mental health – prevention is not the only answer. We also need to bring in, or connect to, additional supports as the need arises, hence the need for the role to be specialised and not just targeting prevention programs in isolation.
- It needs to be said that teaching is already a workforce that is under pressure. How can teachers be expected to add another dimension to their already challenging roles when a large number of teachers are exiting the workforce due to workplace pressure, assaults, bullying and lack of resources to truly cater for their maximum capacity classrooms!

DRAFT RECOMMENDATION 11.5 – VOLUME ONE

Page 397 – improved training for doctors

- I would suggest that we adopt and implement a more intentional and targeted approach in supporting GP's who struggle to address mental health issues? E.g. to address time restraints of currently funded appointment times, lack of confidence due to limited experience or understanding of this niche area, and the sheer overwhelming nature of knowing the full scope of supports and services in a siloed system that is hard to navigate
- When will additional training be added to the scope of psychiatry and GP proficiency? E.g. training is needed in additional areas such as trauma-informed care, recovery-oriented principles, person centred care and co-production planning of services, programs and care planning which could also be a part of their ongoing registration requirements eg AMA & RANZCAP



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DRAFT RECOMMENDTION 11.5 – VOLUME ONE

Page 397 – improved training for doctors (continued)

- We also need to ensure that training (in keeping up to date with research and global evidence-based approaches) is continually embedded, updated and maintained in real time. One solution would be to have KPI's for tertiary institutions, so they maintain their currency and relevance.

DRAFT RECOMMENDATON 12.2 – VOLUME ONE

Page 439 - Guarantee continuity of psychosocial supports

- It is optimal that the contracts be extended for psychosocial supports and that additional measures should be considered to support those who have not been eligible or do not want to apply for NDIS through the National Psychosocial Support Measure
- It should also be noted that funding for such contracts, the National Psychosocial Support Measure and future models outside of the NDIS need to be adequately funded and not short changed so that organisations and services can still provide high quality programs and services to achieve the best level of support and inclusion for the individual consumer
- Organisations are worried that they will not be able to provide the same level of service due to funding cuts that have arose from the NDIS scheme

DRAFT RECOMMENDATION 17.5 / INFORMATION REQUEST 17.1 – VOLUME ONE

Page 86 – wellbeing leaders in schools

- One tokenistic person within a school is not enough to create transformative changes. Further utilisation of current services could be more coordinated and targeted e.g. chaplaincy, student services, administration teams, group programs etc There also needs to be a clear delineation between primary and secondary schools as needs are developmentally different
- In terms of funding it should not merely be capped with numbers of students before funding is finalised but should include social determinant factors instead e.g. demographic of the area/region, proportion of CALD (Culturally And Linguistically Diverse) students, proportion of students affiliated or in direct care of child protection, and comorbid issues such as physical impairments or illness needing assistance or modification for example.



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INFORMATION REQUEST 18.1 – VOLUME ONE

Page 87 Young Adults – tertiary support to link the young person with for online services / resources

- The vocational educational system (TAFE in WA) have a disability support advisory service where students can get additional assistance
- However, due to the stigma of mental illness, institutions such as private training colleges and universities are not so supportive or transparent about what links to supports they can offer or recommend to students (and certainly offer limited, if any, practical supports or adjustments to help sustain their studies)
- A solution to this would be to include promotional material in common computer hubs for students to know where to access resources or even explicit references that are posted to the online learning systems e.g. it would be simple and cost effective for institutions to add direct links to their online portals so that students can know how and where to access online support e.g. the same location where assignments are submitted, unit overviews are located, or could even be posted in a section on the online library homepage for example

DRAFT RECOMMENDATION 22.5 / INFORMATION REQUEST 22.1 – VOLUME ONE

Page 102 – governance and evaluation

- Services have long known the strain of an ever changing funding climate with programs being initiated then pulled due to changing priorities. It needs to be noted that more needs to be done to ensure that any new interjurisdictional statutory authority will remain and be sustained through a bi-partisan approach to eliminate wastage of resources in compiling reports and changing or modifying programs and models, so that there can be some stability and long term commitment within the sector.



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DRAFT RECOMMENDATION 23.3 / INFORMATION REQUEST 23.1 – VOLUME ONE

Page 104 – Structural Reform

- The ‘Rebuild’ model would be the preferred choice, but we also need to make sure that we allow for innovative models of services and facilities
- Current legislation, commissioning and licensing/accreditation processes sometimes limit the scope of what can be provided and restrict innovative and new models of care and service delivery
- There needs to be investment and commissioning for both the clinical care aspect and the community aspects whilst also being open to the fact that hybrid models or wrap around care can also be beneficial in servicing the needs of consumers
- There also needs to be strong consumer and carer representation within such governing state bodies with a recommended workforce target to ensure that inclusion of these voices are not merely representative or tokenistic but play an equal role in decision making at every level of the authoritative body

DRAFT RECOMMENDATION 24.5 – VOLUME ONE

Page 107 – Private health insurance funding community-based healthcare

- There needs to be key legislative changes so that health insurers can remain confident of the quality of such a service in adhering to fundamental accreditation and licencing that are not within the current hospital services framework
- At the moment there is no provision for community-based care within legislation with health insurers wanting to invest in more community-based programs but struggle to fund innovative packages when it comes to community based mental health care and support. Making key changes to legislation would also pave the way for innovative and cost effective models to be initiated and sustained and may in the long run assist in reducing the burden of lengthy inpatient admissions so that both the health insurer and consumer are getting the most out of their money and allocated budgets. This could also potentially have an impact in insurance premiums being reduced so that private health cover could be more accessible to individuals.



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DRAFT RECOMMENDATION 18.1 – VOLUME TWO

Page 723 - Information request 18.2 — what type and level of training should be provided to educators?

- Adequate training needs be provided upon orientation when lecturers start employment within a new educational setting to set the standard and expectations of the service in providing responses and support to mental health needs. This would be for both disclosures made to the lecturers (eg disclosure of previous trauma/abuse or a disclosure of suicidality) and also to the presenting issues and difficulties in learning that a student may face because of mental health difficulties.
- In terms of the level of training, so it doesn't become tokenistic or biased in its form, it would be important to include elements of training in the following key areas: communication and interpersonal skills, how to locate and refer to in campus and other local supports, managing personal reactions, triggers and stress caused to staff from disclosures and presenting issues (managing their own supports and lines of communication within their role), signs and symptoms that a student may be struggling, overview of potential medication side effects and examples of reasonable adjustments that can be made so that lecturers have a good scope of how they can help to maintain their students study pathways.
- In terms of frequency of training I think there needs to be an initial day committed to address the above key areas, but then a reminder within each term to keep mental health needs in the forefront of their role. This could be achieved in a half day workshop or within an hourly meeting across all staff. There could also be a targeted email campaign to remind staff of the supports available to them both to refer students to and also where to go for their own wellbeing and support.

DRAFT RECOMMENDATION 19.2 – VOLUME TWO

Page 747 - Codes of practice on employer duty of care

- A code of practice would assist business owners, managers and human resource personnel to comply within a consistent approach to managing employee mental health and wellbeing, but this needs careful consideration. There are already formal reports and guides to assist in managing mental health and wellbeing however they do not cover the personal, practical and professional aspects needed to fully support both the employees in navigating this issue or the employers who have to navigate this area of concern with them.



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DRAFT RECOMMENDATION 19.2 – VOLUME TWO

Page 747 - Codes of practice on employer duty of care (continued)

- Additional practical guides and targeted resources need to be added to give a more in-depth level of support and functionality to the recommended codes of practice. Elucidate would be happy to work on such an endeavour with Work Safe to ensure the usability and successful implementation of such codes and informational guides.

For further information on any of the above recommendations, please contact Claire Green

Or alternatively you can email general inquiries at info@elucidateinnovation.com.au

Claire Green also presented at the submission hearing in Geraldton, Western Australia on the 20th November 2019.