



Connect Health & Community

Response to Productivity Commission Issues Paper – January 2019 The Social and Economic Benefits of Improving Mental Health

Submission April 2019

Written by Anastasia Sagris-Desmond, Barbara Ryan, Effie Sougias, Jasminka Kosanovic, Kirstie Edwards and Merryn Wheeler

Contact

Amanda Murphy
Connect Health & Community
2A Gardeners Rd
Bentleigh East, VIC 3165
9575 5354

www.connecthealth.org.au

Contents

Key Message	3
Recommendations	3
Acknowledgement	5
About Connect Health & Community	5
Response to the Social and Economic Benefits of Improving Mental Health	6
Assessment Approach	6
Structural weaknesses in healthcare	7
Specific Health Concerns	10
Health workforce and Informal Carers	15
Social Participation and Inclusion	19
Child Safety	21
Mentally Healthy Workplaces	22
Regulation Workplace Health & Safety	23
Funding Arrangements	24
Monitoring and Reporting	26
References	28
Appendix	31

Key Messages

- Apply a whole-of-government approach to achieve cross-sector collaboration through policy to ensure strategies and initiatives implemented will not harm nor contribute to inequities. Collaboration must occur with other systems in mind, clear intersections need to be identified and leveraged.
- The current, fragmented service system is difficult to navigate for health professionals, consumers, carers and community members. Greater integration and collaboration between acute, sub-acute and community health service systems is needed. System reform requires a clear plan and an outcomes focused implementation plan.
- The current, service-specific eligibility criteria is restrictive, hinders accessibility, challenges service navigation and creates gaps and inequity in the service access to, and provision of services.
- Carers are not properly resourced or supported to perform their carer roles. Education, training and ongoing access to support is required to build carers' knowledge, confidence and capability to perform optimally as a carer.
- Advancing the mental health literacy within the broad population will reduce stigma, build the capacity of the community to support itself and those experiencing mental ill-health, and normalise help-seeking behaviours.
- Mental wellbeing of Victorians is compromised by the unequal distribution of wealth, power and resources, the rising costs of living and structural discrimination. Until this is addressed preventative actions will be undermined.
- Greater investment in prevention is required to shift mental health expenditure upstream, to establish multi-pronged initiatives that foster protective factors, reduce risk factors and address the social, economic and environmental determinants.

Recommendations

- Assemble multidisciplinary teams inclusive of different disciplines within the mental wellbeing field, with varied specialised expertise to wrap coordinated services around the client, and provide health professionals who are working with complex clients the appropriate support.
- Invest in system design that increases the funded support of clients in their journeys through a 'step-up/step-down' model of care
- Build capacity into the system for service providers to actively engage with all clients through a person centred approach. Allow additional time for the initial stages of service engagement and enable flexibility of modality type, especially with young people; meet them *where* they want to meet, *when* they want to meet.
- Construct a model where a community service can support parents/guardians/carers when their children require a more intensive and/or specialist service, rather than the current model where services arbitrarily end because the children are no longer eligible for community service based on age and place of residence.
- Provide supportive and environmentally safe spaces to better support high-risk clients who present at emergency departments.
- Undertake research into incentive-based funding or reward schemes for both health and non-health sectors to address systemic issues, such as mandated cross-cultural training to maximise positive outcomes of intercultural collaboration and to reduce potential cultural faux-pas.

- Work with the Department of Education to introduce mental health education into school curriculum, to increase understanding of mental health, normalise help-seeking behaviours and deconstruct ideologies that foster discrimination.
- A shift toward mental health expenditure being spent on health promotion, prevention and early intervention. We want people to identify within themselves symptoms of mental ill-health the same way they self-diagnose a cold, and then seek medical advice. Increasing the mental health literacy of the community is required, through training. Further to this, we suggest the inclusion of the situational approach to mental health literacy that provides a holistic and person-centred approach, normalising distress, applying gender specific considerations and addresses contextual factors such as family and community who can influence an individual's experience (Ashfield et al, 2017).
- Introduce diverse funding models for service delivery. Permit mental health staff flexibility in their service delivery to support better integration and coordination between levels and organisations, initiate prevention based actions and enable client centred strategies to be used in line with community need. Reward outcomes rather than concentrating solely funding outputs, or include incentive-based bonuses.
- Increase health promotion and prevention funding to demand self-determination principles and co-creation approaches are applied in the design, implementation and evaluation of mental health prevention programs. Further to this, we recommend increased funding be used to improve the mental health literacy of the community and develop transitional support programs across the lifespan.

Acknowledgement

Connect Health & Community would like to acknowledge the clients and staff who contributed to this response paper. We recognise the value of their voice, experience and knowledge of the Victorian mental health care system.

About Connect Health

Connect Health & Community is a not for profit community health organisation which has been servicing the community for forty two years. The organisation has 160 staff and 200 volunteers and receives funding from the Federal and State Governments. Connect Health & Community provides a comprehensive range of primary health and community services to support health and wellbeing in the communities of Bayside and the southern part of Glen Eira and surrounding areas, from sites in Bentleigh East and Cheltenham. Gambler’s Help Southern, which is a program of Connect Health, offers a range of free services from 13 sites across the southern metropolitan Melbourne region. Community transport is available for eligible residents in Port Phillip, Stonnington, Kingston, Bayside and Glen Eira. Our dental service does not have geographic boundaries and provides onsite services at Bentleigh East and some community outreach services.

Our vision, “healthy people healthy communities”, reflects Connect Health & Community’s interest in the social determinants of health and the conditions in which people are born, grow, live, work, study, play and age. We continue to invest in wide-ranging relationships with others, spanning: service delivery, health promotion and preventative activity, advocacy, research and education as identified in the Victorian Public Health and Wellbeing Plan 2015-2019. The overarching aim of the plan is to ‘reduce inequalities in health and wellbeing’. Connect Health & Community is committed to providing services in a fair, equitable and inclusive manner to all eligible people within the community. In so doing, the diversity of the community is recognised and acknowledged. This is reflected by the Connect Health & Community Vision, Purpose, Values and objectives depicted in the diagram below:



Response to the Social and Economic Benefits of Improving Mental Health

Assessment approach

Think, equity

A whole of government approach across all sectors is needed to reduce inequalities in mental health. Cross-sectoral collaboration in policy development ensures that programs and strategies will not harm or contribute to mental health inequities. As recommended by the World Health Organisation (WHO) there are existing tools that could be adapted for assessment of policies to determine the impact on mental health equity.

Think, long term

A focus on ensuring sustainability of action is vital for generational change. Long term and sustained policies that reduce inequalities in health through community development, capacity building, partnerships and local organisations working across the life-course and tackling the determinants of mental health can bring about significant change.

Think, self determination

The best way to bring about effective improvements to the prevention and treatment of mental ill-health is to include the people who have experience using them. A co-creation approach both empowers service users and enhances the likelihood of successful programs, services and system improvements.

Think, primary prevention

Strategies to address the unequal distribution of power, money, and resources within the structures of Australian society are necessary for local-level action to be effective and sustained. Research shows there is a clear relationship between mental health and socio-economic status (WHO). 'Alleviating poverty, reducing inequalities and discrimination, promoting access to employment, healthcare, housing and education, can have positive outcomes for mental health' (WHO).

Think, systems

Application of systems thinking can make sense of the complexity of the mental health system and provide perspective of the connections that exist, insight of where the leverage is and present opportunities to intervene to correct inefficiencies, inadequacies and inequities.

Think, health literacy

To acknowledge the work of consumers and carers, and to recognise the value of their participation in this investigation, and to engage and include the whole community, we suggest the application of literacy tools and the use-of-plain language materials when reporting the outcomes of this assessment.

Structural weaknesses in healthcare

Why have past reforms had limited effectiveness and how would you overcome the barriers with effective reforms? What structural weaknesses are not being targeted by recent reforms? How should they be addressed and what would the improvements be?

Past reforms have not tackled nor solved the fragmentation of the health and mental health systems (Beyond Blue, 2018). No incentives have been provided to entice services to become integrated and better coordinated in the delivery of care. Pathways between acute, sub-acute and community services are not seamless and are not easily navigated by services, clients and their carer/s.

For example, a young person who had been in hospital was referred to a specialised mental health service for sub-acute care where the client began appropriate recovery. The client was then referred to a community setting where they had a youth social worker, counsellor and a private psychologist. There was no collaboration between these service tiers.

Connect Health & Community has seen cases where a hospital avoids using the step down model to refer to the sub-acute system and refers directly to community services. For example, a client who was acutely unwell and suicidal, was directly referred to our service, despite the appropriateness of the sub-acute system to support the elevated suicide risk and self-harm they were experiencing while also supporting their family. The long wait list at the sub-acute service and catchment zone allocation of client was cited as the reason for providing this inadequate service response.

Service-specific eligibility criteria is restrictive, hinders accessibility, challenges service navigation and creates gaps and inequity in service access and provision.

Catchment bound eligibility prevents service access for some clients who prefer to visit services close to their school/ place of work, services away from where they reside or for safety reasons prefer to access services close to a designated safe location. Catchment areas are confusing for clinicians referring and almost impossible for community members to understand or seek support through, accordingly.

For example, in the Alfred catchment there is no youth acute/crisis mental health service for teens. As such, young clients who reside in this area need to attend another hospital for mental health acute care. Upon one client's admission at the second hospital there weren't enough beds for him, he was transferred to a hospital more than an hour away. After only three days and limited recovery, another young person, residing in that hospital's geographic catchment, needed a bed so the client was transferred back to the second hospital for a day before he was referred to attend a sub-acute mental health service. The client subsequently became disengaged from the sub-acute mental health service, despite requests for ongoing support from the parents. The service chose to close this clients' file because the client disengaged and showed little capacity to support the parents in their journey of helping their son. There was no closure phone call, visit or written documentation, even after the parents left a message requesting further assistance.

Age eligibility criteria, coupled with catchment restrictions further impedes client focused service access. There appears to be an arbitrary delineation of youth to adult eligibility that is not easy to understand. For example, moving a person from one service to another because they turn 25 years of age can increase risk to client, their families and the client's recovery. This is inconsistent with providing person centred

care; at the right place and at the right time. This is especially true in a fragmented service system where the handover of client care to ensure ongoing engagement and recovery is compromised by its mere design.

Some services have been known to have varying eligibility criterion and service policies based on managing wait-list demand. For example, a sub-acute service had a long wait list, to manage this they included eligibility criteria to try and lessen and limit access.

The raising of ‘tolerance levels’ at both acute and sub-acute levels has forced community health to take on and support a range of clients who traditionally (and officially) fall outside their funded service models of working with mild-moderate support needs. Services, such as ours, are faced with the constant dilemma of working according to funding eligibility and turning such clients away (despite knowing they would not get help elsewhere) or, in good faith and in good will, supporting these clients through the complexities they are experiencing. To enable this, our service is constantly ensuring risk assessment, training and workforce support is up-to-date, while grappling with a constant line of enquiries from community members who fall outside our traditional scope of practice. Evidence of this is the training and constant support we are providing to our Intake Service staff. While employed traditionally as administration officers as a non-clinical screening service; an increase in the number of “urgent” wellbeing support phone calls or clients in immediate distress has meant that all officers have now had to be trained in risk assessment, the Common Risk Assessment Framework (CRAF) and self-care.

The gaps in the system above have a flow-on effect. For example, in a sub-acute service, if two parents are separated and both don’t agree to attend the service with their child, then the child is prevented from accessing the service. This has resulted in some families ending up at services such as Connect Health & Community, where we place priority of service in accordance with the child’s developmental needs, not their parents’ marital status. However, doing this results in more pressure on community services, such as ours, to work with the more complex cases, such as those where only one primary parent is referring. Community health is not sufficiently equipped to address the demand of new clients with such complex presenting issues. Yet, if we do not provide these vital services, clients and their carer/s are left to their own devices to source alternative support or receive no help, further exacerbating already elevated issues. This work is both out of our scope of funded activity and the indirect work is not recognised as funded activity. These service demands mean we are constantly pushed to achieve funding targets and are having to ensure our staff are well trained and supported to work with the complexity of presenting issues.

Different Support Offerings

Case management and social-work type services are both under-represented as forms of support in the community and are then practiced, by some services, according to short-term funding practises, encouraging premature closure of cases and resulting recidivism. People are presenting to health providers with a variety of complex challenges that require both therapeutic and practical support. At the moment funding streams often dictate that these two types of services are generally provided in silos; we provide counselling or case management, but not both. At Connect Health & Community our Social Work service provides both elements allowing practical challenges to be supported first to enable therapy when the client is ready. Because few services offer this flexibility of service we are seeing an additional burden fall onto other Allied Health Service professionals who, while traditionally focusing on servicing their specialist area, are now providing case management support in helping clients and families attain mental

wellbeing support. This too puts an onus on these professionals to work out of scope or for their employers to recognise and continually support their development to enable holistic care. For example, a young paediatric speech pathology client was placed unexpectedly in the care of his father while on the waitlist for speech pathology. Upon assessment, it became apparent the child required more acute service support and the father required parenting support. The paediatric speech pathologist ended up completing the following in support of the family:

- Support in NDIS application process
- Feeding back to the Mother separately, who was in hospital care and only had limited access to her son, but required the knowledge to best support him
- Provided father with emergency crisis pack and a voucher to get petrol
- Liaising with Child Protection, when child was removed temporarily from his Mother's care
- Making referral to Integrated Family Services to provide father with parenting assistance.

Service Categorisation

The restrictive applications of some mental health services can result in a client, with needs that sit outside these eligibility criteria, non-engagement and/or early disengagement. The system structure relies on champions and advocates within services to know the system well and how to work around it in the best interests of the clients. While some services adhere strictly to their criteria and leave clients under-supported, clinicians within services like ours are going out of the way to ensure support responses can be flexible and adaptive to client needs. For example, Connect Health & Community supports clients who are traditionally difficult to engage and offer prolonged and active engagement, where warranted, to ensure opportunities for assistance are accessed via multiple pathways. If we know a client requires a different level of service and might find it hard to engage with another service, we guide the engagement to that service before we close.

The following are examples of restrictive eligibility and their consequences:

- Exclusion, where two parents will not sign up and commit to service, results in non-service or referring to a service that will support. This system implementation can notably impact children whose parents have been violent or abusive, directly and indirectly, as they too are generally excluded.
- Episodic service where the service is cut according to funding and not client need (mental health care plan and (some) Integrated Family Services).
- Specialist service provision for paediatric related trauma that is not well provisioned/supported. For example, selective autism and post-traumatic stress disorders are not catered for in the public mental health system, outside the assessment and diagnosis stage.

Communication inefficiencies

A lack of integrated communication or restrictions on information shared between services is a constant challenge for some services. Clearly, there are issues of risks to clients and/or others that could be missed without such integration, but these also pose other more subtle challenges. For example, Connect Health & Community supported parents who had accessed and been discharged from several local services for their child, but without the parents' consent to share information, we could not readily stop this. Despite our active efforts to advocate for service consistency with the parent, this child's development was made more vulnerable by being exposed to possible inconsistent service provision and risk that we couldn't readily assess.

Patchwork was an example of a system where such vital information could have been shared, but it was defunded and Community Health Services access to the new system was prevented.

Client engagement descriptions

The definitions and applications of the terms “voluntary” and “active engagement” need revision. Sub-acute services appear to use these terms to close a service early or not actively engage with clients where there are challenges. We have reports of sub-acute services telling parents they cannot make a young person attend because it is a ‘voluntary service’, but also report they cannot facilitate any active engagement because their service cannot sustain the help required. We also witness this with parents who are choosing to not engage in a service on behalf of their child. The only time this engagement becomes assertive or mandatory is when risk is so high, it triggers Child Protection involvement. By that stage the potential damage and/or trauma on all involved can be substantial. Building capacity into the mental health system for services to actively engage with all clients at the initial stages of service is recommended, as is building in flexibility of modality type, especially with young people; meet them *where* they want to meet, *when* they want to meet.

Constructing a model where a community service can support parents when their children require a more intensive and/or specialist service is recommended, rather than one where services arbitrarily discharge because the children are no longer eligible for community service.

Specific Health Concerns

What changes should there be to mental illness prevention and early intervention to reduce the prevalence and severity of mental illness?

People with a lived experience of mental illness, report significantly low levels of self-determination (Taylor et al, 2016). Research shows that maximising the opportunities for personal autonomy and self-determination are protective factors for mental ill-health. Self-determined motivation is strongly associated with engagement in positive health behaviours such as increased medication and service adherence, and other activities that promote wellbeing (Taylor et al, 2016).

Structural poverty, disempowerment of population groups and the unequal distribution of power, money and resources perpetually undermines prevention efforts and prevent the shifts in mental health prevalence at a population level. Evidence reveals action needs to be taken. Children and adolescents in low income households are twice as likely to experience mental health disorders compared to their counterparts from high income households (Department of Health, 2015). In recent years, we have seen wage growth fall continually and real wages have failed to keep up with inflation over the past three years, meaning that essentially, workers’ earnings are declining (Parliament of Victoria 2018). With declining income, the standard of living is required to change, placing stress on individuals and families. The Parliament of Victoria identified that “low-income households and those on government pensions or Centrelink allowances have faced the largest increases in the cost of living”. Melbourne is now ranked the fifth most unaffordable major housing market in the world and the impact has been greatest on low-income earners, with mortgage and rental stress is also rising across all household types (Parliament of Victoria 2018).

Social, environmental and economic determinants need to be tackled at a societal level to create population level changes to reduce the prevalence of mental health in Victoria. If individuals do not feel

in control of their lives, feel that they have capacity to make decisions and/or have feelings of hopelessness they are unable to thrive and remain productive over a lifetime.

Good parenting is an enabler for good mental health. Environmental and economic stress inhibit parents to always provide optimal care. Research shows the early years to be a critical period in a person's life to build strong cognitive and social foundations for optimal childhood development that supports good mental health and wellbeing (Beyond Blue, 2018). Transitional programs across the life-stages that promote mental health, build resilience and respond to key protective factors and risk factors critical for prevention and early intervention are recommended (VicHealth, 2017). Significant life changes can trigger mental ill-health, bringing about feelings of (but not limited to) peer rejection, isolation and alienation, discrimination, conflict, low self-worth, loneliness and stress (WHO, 2005).

Programs that normalise feelings and help-seeking behaviours, foster inclusion, support the development of coping mechanisms and increase access to information and services, can shift attitudes, reduce stigma and change behaviours. Transitional milestones begin in early years, moving to childcare or play groups, kindergarten or pre-school, primary and then secondary school, then to part-time employment, further education or employment, parenting, and retirement. At each point individuals process a number of fears and challenges and their capacity to manage the change is dependent on many factors - for example employment and housing stress, access to support, and skills and capability to cope.

To better support young people, it is necessary to educate parents to ensure they are prepared for supporting their children through the pre-adolescent to early adult years. Research shows this is the time that many challenges/risks and mental illnesses begin, but we do very little to prepare the family and community, as a whole. Basic information is needed for parents and pre-teens with a focus on understanding adolescent and early adult behaviours in regard to all facets of wellbeing: including social, economic and environmental factors, such as mental health, drug and alcohol, social media, education, employment, peer relations, consent and rights, and financial literacy. Although there is an abundance of related education information contained on the internet and provided spasmodically by services of their own accord, there appears to be little in this current education structure/curriculum that allows services to routinely and consistently provide ready access to this type of support. For example, last year, Connect Health & Community noticed a rise in referrals for young people presenting with dual diagnosis issues and a number of suicides in our local area. In response we ran a community education session on drug, alcohol and suicide awareness, and we received an overwhelming response from the community. We funded the session our self, and were only able to deliver it because staff were passionate enough to give their additional time to do so.

It is also important to enhance service navigation for users to provide the feeling of autonomy and control. Applying health literacy principles and using a co-design approach will improve the ability for all to identify and access the services, support and care required.

Which forms of MH promotion are effective short and long term and what evidence supports this? What changes do you recommend to address the specific issues of suicide and co-morbidities among people with mental illness? What evidence do you have to support this? What health care reforms do you propose to address other specific health concerns relating to mental ill-health? What supporting evidence do you have?

Prevention action that counters discrimination, advances inclusion and creates safe and respectful communities can build belonging and prosocial behaviours, ultimately enhancing mental wellbeing at a population level.

Evidence suggests that multi-dimensional approaches to suicide prevention are most effective. They appear to act synergistically to reduce stigma, change attitude and behaviours, in particular among men and boys, which in turn contributes to reducing suicides rates (Roberston et al 2015). Applying a multi-dimensional approach considers all aspects of a person; their diet, emotional, environmental, spiritual, social, vocational, intellectual and physical wellbeing and the interactions that impact mental wellbeing (Hidaka, 2012).

Alarmingly, suicide is the leading cause of death among people aged 15-25 years in Australia (Black Dog Institute, 2017). There is disparity within the youth population, with significantly higher rates of suicide among Aboriginal and Torres Strait Islander communities, gender and sexually diverse communities and male cohorts. Suicide prevention work is required alongside systemic action to redress the institutionalised discrimination that occurs for subpopulation groups. Connect Health & Community is establishing a community suicide prevention network, with whom we will work collaboratively to identify actions required to bring about change in our community.

Implementing incentive programs for private and non-private organisations to become inclusive services and settings would provide meaningful support to sub-population groups who face conscious and unconscious discrimination within the community. For example, encouraging rainbow tick accreditation to reduce the implicit bias felt by gender and sexually diverse people and communities would help break down barriers. Incentives could be linked to insurance, for example work cover.

Crisis supports are not able to impact prevention of suicide because they are working within a system constantly under pressure and needing to push these people back into community supports. These supports, sub-acute and community, are under resourced and trained to deal with such complexities and if they do, do so without any funding support. Increased funding and flexible funding guidelines are required to allow sub-acute and community staff to deliver prevention based initiatives.

Clearer understanding of what different age groups require in regard to suicide prevention is essential. We must work with different cohorts and sub-population groups to develop responsive and relevant actions. Better and more thorough family support is essential for those at risk of suicide and the families of those who have died by suicide and those impacted by another person's suicide. The ripple-effect of suicidality and suicide is far reaching, it can trigger different thoughts and feelings for people directly and indirectly connected to the individual.

People who are sexually and gender diverse face up-to twice as much abuse and violence (including physical, mental, sexual or emotional) than their heterosexual counterparts. The discrimination, prejudice

and exclusion can lead to increased risk of depression and anxiety, substance abuse, self-harming and suicide thoughts (Beyond Blue, 2019).

For example, a young transgender person was subjected to abuse from their family after they chose not to deny their true gender. The family gave the young person an ultimatum, to either live as the sex they were born and conform to the family's culture and interpretation of religious beliefs or leave. This rejection forced the young person into supported accommodation and caused financial pressures, exacerbating their existing mental ill-health.

A review of crisis triage procedures for patients presenting as 'at risk' is required; we have had multiple clients report extensive waits in emergency rooms (ER). Evidence of this is already well established in state-wide reports on ER wait times and issues. For example, Connect Health & Community had an adolescent client (accompanied by a worker) wait seven hours in a busy, chaotic waiting room for an assessment. Connect Health & Community had another teenager wait five hours in the same setting, only to be told on assessment, *"You're not psychotic mate. Those are not voices you are hearing. You need to decide if you are going to pull up your socks"* He was then discharged.

Tighter social media controls; especially for young people is necessary to protect young people from cyber-bullying, exposure to sexualised material, offensive and discriminatory content that directly impacts an individual's beliefs, self-worth and mental wellbeing. "Facebook depression, develops when teens and preteens spend time on social media sites and then begin to exhibit classic symptoms of depression due to the intensity of the online world" (Mir et al, n.d). Social media is a platform where individuals can display their positive attributes and aspects of their lives, it also permits the individual to filter or not reveal aspects of their life (Mir et al, n.d). The constant showcase of success can greatly impact the mental wellbeing of people who are vulnerable. Research has shown regardless of the time spent on social media, adolescents who use multiple social media platforms have an increased likelihood of symptoms of depression and anxiety (Mir et al, n.d).

To sustain participation in mental health promotion programs it is critical that settings adopt targeted population group recruitment processes and are culturally sensitive to the specific requirements of subpopulation groups. It has been identified that adopting a health literacy lens approach is essential and successfully engages community members. For example, use of the word 'activity' in place of 'health' i.e. 'regaining control' instead of 'help-seeking', can make programs and projects more familiar and less discouraging (Roberston et al, 2015). Employing staff who reflect the subpopulation group or employing peer leaders to co-facilitate planning and delivery of activities can create a safe space and increase participation. Activity-based interventions need to be familiar and culturally relevant to the cohort to achieve success, this has been proven for promoting and improving the mental health of children and adults, and in particular older men. People are more likely to engage when they feel connected to the intervention, where there is relevance and it provides a group context that promotes social inclusion and enjoyment. Examples include the Men's Shed, gender specific activities in residential care (Roberston et al, 2015) and community based culturally specific support groups.

Offering community-based interventions close to where the community reside improves the connection helps promote social inclusion and provides a safe socio-cultural space (Roberston et al, 2015). In addition, recruiting community members to assist in designing, implementing and evaluating

collaborative mental health promotion programs, shares ownership, control and problem solving thus promoting mental wellbeing (Miller 2016), and responds to the protective factors for good mental health.

Incorporating peer and mentor roles into community-based initiatives supports ongoing evolution and relevance of programs, participation of specific target groups, skill development and responds to protective factors for mental health. To help aid community health promotion to sustain this model, funding is required for community based roles. Presently, community and philanthropic grants do not fund salaries and wages, challenging the implementation and sustainability of this model.

Connect Health & Community delivered an 'emotional wellbeing' group for adults who experienced a broad range of issues (such as anxiety, depression, trauma, family violence and emotional disorders) and experienced difficulty regulating and understanding their emotions. The group was established in response to the elevated levels of high or very high psychological distress being experienced among clients through growing service demand and wait lists for counselling and psychological services. The results showed a reduction in symptom severity for both depression and anxiety, with improved symptom reduction of anxiety over depression. Treatment gains were found to be maintained three months post follow-up (Connect Health & Community, 2017). We learnt monitoring and real time reviews, flexibility with the delivery model and less rigid funding is required to help staff identify immediate changes and enhancements for group participants to maximise their benefits.

Co-created and regular education sessions for the community, that open dialogue, normalise help seeking behaviours, build understanding and social supports would build community capacity and prosocial behaviours. Service delivery experts are required to deliver these sessions with support from health promotion staff who can facilitate the planning, implementation and evaluation. Presently, service delivery staff are restricted to meet service targets, flexible funding structures and separate funding for prevention actions is required to facilitate this function. Appointment-based funding models drive output-based service delivery, rather than outcome-based services. Diverse funding structures with flexibility allow service provision that meets the clients' needs and goals.

Mental health promotion programs contained within school settings are not consistent and planned at a State level, leaving schools and local services to plan and implement much of this without larger direction and support from the government. This results in unequal and unfair distribution of support and information for students, parents and teachers, and is based on the individual schools resources and capacity, not their need. The achievement program that is in place supports school environments to change but the ability to address systemic and entrenched structures is limited, and there is no subsequent funding provided to facilitate health experts (service delivery staff) to deliver education sessions on top of their usual duties.

Funding community health services to work with schools builds relationships and increases awareness of local primary health services and provides a local perspective. This approach supports co-location of services in schools, grows referrals and reduces barriers for access, in particular increasing access for older students who do not require parental consent. Building health promoting school communities requires funding and cross government action at the State level. Embedding mental health education into school curriculum, similar to reproductive and sexual health, can create safe spaces for dialogue, reduce stigma and cultivate understanding that can flow onto workplaces in future generations. Teachers could be trained in Mental Health First Aid, and deliver this to students. With students trained to deliver Mental

Health First Aid to parents and/or guardians or in community sports settings. This type of initiative could be monitored and evaluated by local health promotion staff from community health services, if properly resourced.

Currently, schools' resourcing of mental wellbeing appears to be largely reactionary, without a lot of work being put in place for well-planned and structured prevention and early intervention models. A plan where services such as Headspace and Beyond Blue partner with local services and schools to intervene early, is needed.

In future, we want to see a shift toward mental health expenditure being spent on health promotion, prevention and early intervention. We want people to identify within themselves symptoms of mental ill-health the same way they self-diagnose a cold, and then seek medical advice. Increasing the mental health literacy of the community is required, through training. Further to this, we suggest the inclusion of the situational approach to mental health literacy that provides a holistic and person-centred approach, normalising distress, applying gender specific considerations and addresses contextual factors such as family and community who can influence an individual's experience (Ashfield et al, 2017).

Health workforce and Informal Carers

Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? How could this arrangement improve population mental health, participation and productivity? What restrictions exist on the scope of practice for different professions, such as clinical vs other psychologists, social workers, GPs and nurses? Are these restrictions warranted? What could be done to reduce stress and turnover among mental health workers? How could training and CPD be improved? What can be done to increase uptake?

In Victoria, we have a growing population and complex social, environmental and economic issues impacting the mental wellbeing of our community. This triggers greater demand for services at both ends of the spectrum. The demand is overwhelming and results in pressure on the system and increased stress on the workforce. As a community health service we are receiving more complex clients due to the limitations and pressures on other parts of the system. We have recognised that staff in hospitals are pressured to discharge clients promptly, who at times are not ready or safe for release. As a community health service we employ clinicians to work with mild to moderate-need clients. Yet we have experienced a shift to more complex clients with clients presenting with challenges across the whole spectrum because of, limitations in access due to availability and eligibility criteria, increasing the risk for our service and staff. For example, this increasing demand and complexity is clearly evident in the calls Connect Health & Community's Intake staff receive. To ensure our staff are resourced and well supported for the rise in complexity of callers and referrals we have had to invest in training and supervision, in type and volume not previously required. All our Intake staff have been trained to complete the full 'risk assessment to self and family violence' common risk assessment framework (CRAF) and we are investing in vicarious training and support for our staff.

Mental health service delivery is provided through a fragmented model that is challenging to navigate by workers, clients and carers. There are limitations with having segmented specialised services. As a client, you may need to visit multiple services which can require absence from work or study and care arrangements. Clients having to provide their history and needs to each service can cause fatigue and inadvertently, resulting in information not being provided, it can also result in re-traumatising the client.

The nature of care can be uncoordinated between services and hinder the client's ability to recover. As a practitioner, staff are required to support clients with varying needs of mental health illnesses and complex social and health issues. Practitioners cannot be experts or trained in all cases that present for help.

Multidisciplinary mental health care teams

In place of current siloed and specialised services, it is essential to have multidisciplinary teams positioned in close proximity to each other across the state to better respond holistically to individual client needs. More service sites and comprehensive teams better-resourced and located for clients, will improve access and outcomes. We need a coordinated and integrated service team wrapping services around the client to enhance their recovery with better professional support for practitioners. This system would need to integrate workforces and systems across the service levels of acute, sub-acute and community, to enhance the journey of the client and/or their carer.

A service team could include a mix of general practitioners, psychiatrists, psychologists, case workers, social workers, counsellors, aboriginal health workers, sexual and gender diverse health workers, mental health nurses, and health promotion practitioners. Expertise in (but not limited to) alcohol and other drugs, gambling, family violence, trauma and homelessness would sit across the team. Service teams could exist for early years, youth, adults and older adults or include specialised workers in the multidisciplinary teams with expertise in working with these age cohorts. Service staff would represent and be reflective of the Victorian community they serve.

A multidisciplinary team can support professional collaboration and aid practitioners in delivering appropriate care for clients, build their capacity, alleviate risk and reduce stress and pressure felt by workers. Identifying a competency criteria could assist with identifying scope or restrictions on practitioners and be based on skills and experience. Multidisciplinary teams can reorientate services and build greater knowledge and respect across professional service providers.

Service teams would provide direct care to the client, case management for co-occurring social and health issues, education and direct-care for carers and key people important to support the client's recovery and support service navigation, including inward and outward referrals.

Service teams would not have geographical boundaries, clients would be able to choose which service team they want to receive services from. This would enable clients to access services based on what works for them. Services would be able to support clients with complex, moderate and mild needs attributable to the multidisciplinary team.

Employing a model where the social networks for a client receive education and support to better help and care for the client builds the capacity of the community, reduces stigma and minimises the risk for clients and carer/s.

Integrated system

A way for the systems to integrate, enhance communication and strengthen referral pathways is recommended. To further enhance the level of care provided and improve communication, shared access to client assessments, discharge notes, and treatment plans between services is necessary. For example, in the current situation when a client presents to community health after being discharged from hospital

and the community service has no access to their records, it places stress on the client and practitioner and can result in duplication of service provision. For example; where a current Connect Health & Community client is hospitalised, the hospital is aware of our service provision, but provide no correspondence upon discharge. This results in clinician time following up discharge, the client re-telling their story and treatment being put on hold to ensure that community support is in line with what has occurred with the client while they are an inpatient.

Making shared care and direct service partnerships an expected part of routine professional supports for both the clients and the workforce would be valuable. At the moment the existence and maintenance of these partnerships rely on the champions within organisations and representatives' good-will to dedicate time and priority to this type of workforce and client support.

Training

Connect Health & Community has noticed an increase in the number of clients presenting who have experienced trauma. There is an increased need for health staff to receive training in trauma informed practice, not merely mental health staff. Supporting clients who have experienced trauma is the role of all health practitioners who come into contact with that client, so as to ensure no harm is caused to the client or practitioner.

What changes could be made to how informal carers are supported (other than financial) to carry out their role? What would some of the benefits be?

Education is key and treating informal carer/s as part of the health care team for the client can enhance the ability of carers while providing greater support to both the carer and the client. When a parent or guardian takes on the role as an informal carer they are placed in the role out of love and responsibility, not due to their knowledge, skills and experience. Informal carers are often uneducated about mental illness and the likelihood of co-morbidities, the behaviours expected, how to best manage, how to support and care for the clients and themselves, and what help is available.

Acute and sub-acute services are under extreme stress and pressure to provide constant throughput, they are unintentionally or otherwise, placing that responsibility for a client's safety and/or wellbeing support back on the community supports or families of the client.

Mental health practitioners have access to clinical supervision and other professional support yet we ask untrained community members to take on the role as a full- or part-time carer without any training or support. Providing low-cost and free services for carers is required. We need to help carers access the support and assistance they need to undertake the role as a formal or informal carer. For example, when a person registers as a carer they could be provided with Government funded or subsidised Mental Health First Aid training.

Case study one

Connect Health & Community is currently supporting a mother whose son, experiencing schizophrenia and drug use, has been in and out of hospital for a long period of time. This mother shared with us her experience of being an informal carer.

“When I went to a hospital it was a terrible experience. My son was in white clothes, a wrap-around gown with his buttock exposed. No shoes and his face was bruised. The unexplained bruising, was from too much legal drugs being administered and he fell and hit himself. I wasn’t prepared for what I saw. It was so shocking and traumatic to see my son in this way. I wish someone could have taken the time to explain to me about my son, to have educated me and to have given me information. I needed someone to communicate with me.

My son absconded from the hospital on a number of occasions. There needs to be better security and supervision of patients, and they were under-staffed. While in hospital my son had access to illegal drugs and to alcohol and was having sex with other patients in the hospital. A nurse told me this information and my son also told me this information. Being in a hospital, I thought my son was in a safe and protected place.

When my son was released from hospital, nobody told me anything. My son was discharged into my care without them having asked me or providing me with any formal support - and I had no information on how to protect myself. I would have liked to have been part of discussions and case conferences with doctors involved while my son was in hospital and I would also have liked to be part of the discharge plan. Help and support was never offered. There was no consistency with psychiatrists. Once, I overheard a psychiatric nurse say that they were wasting their time with my family.

At the time my son was at hospital, I was coming in to Connect Health & Community for dental services and asked if there was counselling service offered. At this time, I felt like I was inside a dark tunnel and I felt claustrophobic, stuck, like I was in a dark hole. I found the experience here very helpful; mainly the consistency in staff.

I felt very ashamed, embarrassed and not accepted – but Connect Health gave me a safe place to heal. Since receiving support I feel more accepting of reality and of my son’s reality. This was the place where I opened up about my own big secrets, bulimia and sexual abuse. It was the one place where I did trust and I was consistently accepted and not judged. I was also able to access the support I needed as I did not have to pay for the service, I am financially stretched.”

Case study two

Looking at where to start to look for mental health services is overwhelming. I would do a google search on my mobile phone to source support. Navigating the system to try and find the right thing for yourself is difficult. When I was having trouble with my son, I found it difficult to help him because of his age. I rang Task Force, Drug and Alcohol counselling services, Lifeline and each service indicated that they couldn’t help my son because of his age. My son was depressed and suicidal. One service recommended the other services. I rang the CAT team and I was advised that my son had to ring the services himself to organise the care required. I wasn’t able to assist my son to access services. Anyone over 18 is considered an adult, and are encouraged to use their own initiative to get the help they require. Many barriers were presented due to his age. I am my son’s legal guardian and carer but because he was past 18 years of age, my son had to contact the mental health services himself to obtain support. My son visited a GP, but the GP informed me to leave him as he was so angry with the world.

Being a busy single mum prevented me from pursuing alternative mental health services to support my son. The only service my son accessed was counselling at Connect Health & Community when he was

aged 9-10 years. Counselling has helped me in the past with my mental health symptoms. I commenced counselling when my son was young and after my divorce.

My son has a job, but he is not receiving regular work by his employer. This prevents him from paying rent and bills and he regularly relies on me to pay for them. I have had to stop paying for his bills as it was causing me financial and mental stress. Centrelink doesn't provide enough services to support my son with finding a secure job. Sourcing secure employment would prevent some mental health symptoms my son is experiencing.

As a child, I was bullied by my parents. I was the older daughter. My mum and dad were very strict and I was required to help more with the chores in the home. I left school around age 17 and obtained an office job which I was quite good at. When I was young, my parents prevented me from interacting with anyone that wasn't Jewish. When my father was angry, he used to hit out on me all the time. My mum directed a knife at me because I wasn't helping in the kitchen.

My mother told me a story of her and her sister escaping Poland. My mother's sister asked her to escape with her, but my mother said they can't leave their other little sister. Her sister then said I can only take you or her. So my mother chose to escape with her sister and they left their little sister behind. When my parents migrated to Australia from Poland, I was responsible for teaching my parents English. It was a very hard time and my family have been through a lot.

I also look after a friend in my home. He has mental health issues but can't identify them. He forgets a lot too. He doesn't want to access health services as he doesn't see anything wrong with him. I'm very tired and I just want to do something for me. I currently don't work but volunteer in my community.

I would like to see current mental health services to have no barriers in particular to age of a person and to have an easier pathways to access public mental health services. All mental health provisions need to allow carers who are caring for a friend or family member who is experiencing mental health illness to navigate and mediate the mental health system on their behalf to advocate, mediate and provide care and access to prevention services.

Social Participation and Inclusion

In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs? What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do? Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups? What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

Isolation is an increasing concern for Victorians. There is an increase in lone-living, single bedroom dwellings and people working from home. There are less incidental human interactions with the introduction of technology; self-service at supermarkets, online banking, online shopping, and pre-recorded phone message services and so on. Opportunities to meet like-minded people is challenging and usually requires financial resources, with increased living expenses social occasions are restricted for

many, making it incredibly difficult for low-income and unemployed individuals. For particular sub-population groups, different forms of discrimination are key barriers to engaging in social groups and social settings, for example (but not limited to) wheelchair accessible venues, noise-restricted venues, welcoming and safe venues for Aboriginal and Torres Strait Islander people, people from refugee or asylum seeker backgrounds and people who are sexual and gender diverse.

Cross-cultural training is effective in increasing knowledge, changing the narrative and community attitudes, empowering those who have not traditionally had a voice, nurtures empathy and understanding and can lead to behaviour and systemic changes. Aboriginal and Torres Strait Islander cultural awareness training is delivered in many work places but not all, and in some organisations it is not mandated. Increasing knowledge and celebrating Aboriginal and Torres Strait Islander people and their culture as our First Nations People is important to building a foundation of social responsibility and tolerance, and critical to closing the gap between First Australians and other Australians. Better recognition of First Australians and their culture within Victoria can be achieved. For example, changing road and public signs to include the traditional name in local Aboriginal language alongside the English name. Unless the culture is overtly visible in everyday living and appropriate recognition and value is shown the gap will remain.

Opportunities to participate in extra-curricular activities is a privilege that some but not all can access. This problem in itself is complex, and affects people differently, until we understand these complexities we are unable to collectively solve and reduce the barriers that exist.

Monitoring improvements in mental health outcomes for the community requires identifying what is important to the community, what do they identify as measures of success and what improves their social participation and inclusion. For many feeling like a human is key, access to housing, sanitation, food, education, employment and transport. Having pride and self-worth, the resources to participate in the community and feeling valued sustains individuals to function and engage in social interactions.

Connect Health & Community provide a number of social programs to the community to support those older adults in need of social connection and younger people with a disability. Support, in a similar way, for those people needing to maintain social connections due to their mental wellbeing vulnerabilities is sorely needed. Accessing such groups within a community organisation like Connect Health & Community offers convenience for the client, as it means that their services are all in one place. We also host a specialised playgroup for families of whose connections to their young children are compromised in some way. Specialised playgroups, such as these, where one on one support can also be offered to carers and family's means that individual mental health recovery is supported in the context of one's family and community systems.

Case study three

Connect Health & Community has been delivering a walking group for the past ten years, in partnership with Kingston City Council, Westfield, Kingston Active and Central Bayside Community Health Services. The participants are older adults who have reported that social connections are the main benefit they receive from the activity. Sustainability of this group is challenging, the fiscal environment has hindered the ability of Westfield to continue to fund the activity for the past two years. There are approximately 30-40 people in each walking group, who regularly benefit from this weekly walk. In a recent survey of 41 participants, 88% reported social connection and making friends was the main benefit, 24% reported that the walking group is the only organised group they participate in and 93% reported that in the past 12

months they have had no falls as a result of participating in the activity. The program costs approximately \$5.00 per person per walk, there will be 88 walks delivered this year by a trained and experienced fitness instructor who also provides stretches and exercises along the walk.

Child Safety

What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?

What, if any, alternative approaches to child protection would achieve better mental health outcomes?

Interface between mental health services and child protection and those services directly referred to by Child Protection need to be designed with flexibility and adaptability in mind, to cater for differing client needs. For example, those services striving for targets under short to mid-term funding close cases prematurely to attain funding targets rather than support client goals. The integrated family services at Connect Health & Community are funded to complete short term intervention but complexities of the referrals are not supportable in that time frame, resulting in us extending our service provision and ultimately impacting on our capacity to meet funding targets. Our service is (and has been) working with numerous families (in need of family support) who report that they were receiving services elsewhere previously but the service/s had to close because of their funding model of short term intervention. Ultimately, this puts strain on our services in the system to reconnect such families to support or provide similar support ourselves. Obviously this engagement and disengagement pattern for families is not conducive to optimal family functioning.

We need to research into alternative forms of mental health support to better suit the child/adolescent developmental phase. For example more mentor program type options, options via online modalities, outreach in different settings and times. Our services still largely present in an office, within business hours, for young people. Co-design such services with young people to ensure a system is built in line with their needs and stage of development.

A system where those children identified as most vulnerable are given a more permanent support team. For example Connect Health & Community has found, the six monthly rotation cycle of psychiatrist registrars in the local adolescent sub-acute services rotation has contributed to disengagement of some very vulnerable young people and families. While we are aware of and totally support training our future workforce members, this should not be done at the expense of those clients most at risk of disengagement.

In situations of high risk to family members, particularly children, a model where all involved services use a shared care approach in the best interest of all the families. At the moment, such a shared care approach is mostly used once families reach the pointy end of the system, rather than a model of care that is used to intervene early and plan collaborative, future care.

Mentally Healthy Workplaces

Structural inequity that occurs between different subpopulation groups is a leading contributor to poor mental health.

Australian women continue to receive unequal pay to their male counterparts for performing the same work. The national gender pay gap in Australia is at 14% currently. Based on the 2017-2018 Workplace Gender Equality Agency (WGEA) data, men working full time (total remuneration) earn on average \$25,717 more than women working full time, a gap of 21%. The full-time base salary gender pay gap for 2017-2018 was 16%, resulting in women earning on average \$15,457 less than men working full-time. The data illuminates a gender pay gap favoring full time working men over women in every industry and occupational category across Australia (WGEA, 2018).

On 1 January 2018, Iceland became the first country to officially codify equal pay for both men and women, taking a major step forward to closing the gender pay gaps. The new law stipulates that employers with 25 or more employees are required to obtain a government certificate stating that they convey equal pay policies to all individuals regardless of race, religion, disability and occupation disability, age and sexual orientation or are at risk of being audited and fined (United Nations Human Rights – Office of the High Commissioner 2019). Iceland has been named in the top ten country's for gender equality for the past nine years running by the Work Economic Forum's Global Gender gap Index (Statistics Iceland, 2017).

Sweden, Austria, Denmark and Portugal are required to report gender identified pay data to the government each year. France and Sweden are following and businesses are required to review their pay practices each year (European Commission, 2014).

Women who continue to face discrimination within their workplace will face a lifetime of income inequality. Closing the gap requires strengthening antidiscrimination efforts by political leaders and adopting a suite of work-life policies, including extending paid family and medical leave to match the practices of Scandinavian countries; paid sick days, affordable child care and paid parental leave (European Commission, 2014).

These antidiscrimination policies and structures need to be applied to all subpopulation groups who face unfair treatment in the workplace. Reports identifying other identifiers other than gender could be used to assess pay equity for all, responding to the intersectionality of race, sexuality and gender, disability, religion and age.

International trends in paid parental leave entitlements indicates parental payment rates tend to be lower in English speaking countries. Positive attachment and early bonding, positive parent-child interactions, early cognitive stimulation and good parenting are all protective factors for mental disorders and directly impacted by paid parental leave entitlements (WHO, 2005). Australia is the one of lowest in the Organisation for Economic Co-operation and Development (OECD) for full time equivalent weekly parental leave payments (Organisation for Economic Cooperation and Development 2017, Australian Government, Workplace Gender Equality Agency, n.d). Australia's length of maternity leave entitlements is 18 weeks, compared to 39 weeks in the United Kingdom. Sweden lead the way in offering 60 weeks of paid leave, whilst Germany and Denmark follow with 59 and 50 weeks respectively and the OECD average is 54.1 weeks paid leave per year (Organisation for Economic, Cooperation and Development 2017,

Australian Government, Workplace Gender Equality Agency n.d). Paid parental leave entitlements for men or partners in Germany is 8.7 weeks at 65% of their average pay rate compared with Australia who offers 2 weeks at a minimum average pay rate and excludes same sex marriage partners (Australian Government, Workplace Gender Equality Agency, n.d.).

Other countries that employ gender anti-discrimination interventions are Finland, Norway and Sweden who have introduced Cash for Care benefits. A family policy that provides financial payments to a parent with a child under the age of 3, who does not use publicly financed childcare services. In Sweden, the allowance is not paid to parents who receive unemployment or sickness benefits. The Finland supplement also consist of a sibling allowance for any other child in the family under school age (6 years or under) who is cared for in the same way. This incentive supports parents to have the choice of re-entering the workforce or staying at home to care for their child. Whilst the policy is gender neutral, the allowance is predominantly used by mothers, and inadvertently, population growth has occurred in these countries as parents are feel supported to have more children (Ellingsaeter 2012).

The Victorian Government could lead the way in adopting international legislation and policies to advance inclusion of all and reduce the unfairness that exists in workplaces and employment practices. Incentivizing or subsidizing the delivery of unconscious bias training and unconscious bias employment practices including recruitment, can reduce discrimination in the workplace and build mentally healthier workplaces and communities. Governments must model and adopt innovative ways to ensure all businesses respect the human rights of their employees, volunteers, customers and fellow citizens.

Regulation of Workplace Health and Safety

Workplace health prevention considers the physical work environment, personal health resources, the enterprise community involvement and the psychosocial work environment (WHO 2016). Without the investment of leadership engagement and worker involvement in health promotion and disease prevention initiatives and practices, this can lead to individual's in the workplace feeling undervalued, experiencing workload stress from unreasonable time frames, unable to cope with vicarious trauma that results from empathetic engagement with traumatised clients (LaMontagne et al 2014, HeadsUp n.d.).

Organisations have greater evidence of the individual staff benefits gained from participation in workplace health programs and activities rather than organisational strategies such as policies, this is due to a lack of capacity and capability to undertake the research (WHO 2010). Connect Health & Community offer staff and volunteers a suite of individual interventions that contribute to mental wellbeing, including:

- The Family Violence Protection Act (Vic 2008) provides the workforce with an extra 20 annual leave days per calendar year
- Provision of an Employee Assistance Program
- Clinical supervision and operational supervision
- 15 minute walk break, twice a week
- Fortnightly mindful meditation sessions conducted by an onsite Psychologist voluntarily
- Quarterly healthy shared lunches
- Training for staff, volunteers, consumer reps and students to manage symptoms of vicarious trauma and workplace stress, workplace conflict, mental health first aid training.
- A time out room for individuals to engage in listening to relaxation music, read inspirational metaphors and participate in strengthening and gentle exercise.

- Weekly yoga (whilst provides many physical benefits, this has assisted with managing stress and anxiety amongst staff who have participated)
- Creative art therapy opportunities

Connect Health & Community has implemented organisational policies and interventions, including:

- Responding to vicarious trauma in the workplace
- Serious injury or illness of a staff member
- Access, equity and diversity, prevention and unlawful bullying harassment and violence policy
- Workplace gambling; and
- Recognition programs

Further work needs to be considered in Victoria, to adopt a whole of organisational approach to addressing and preventing mental health symptoms amongst the workforce. Inclusion of the following interventions could greatly improve recovery, productivity and enhance mental wellbeing of employees, volunteers and indirectly the communities. These include:

- Employing a mental health workplace policy (WorkSafe Australia 2019)
- Increasing the number of sick days per calendar year to also include mental health leave for employees
- Employing working from home policies
- Flexible working conditions
- Management training in mental health to act as a first responder to support their staff and community members
- Undertaking a mental health and wellbeing audit of staff which is incorporated as part of organisations accreditation process
- Integrated anti bullying training and programs (that is provided in a face to face, interactive training model)
- Peer educator schemes, provide additional mental health training to key champions (not trained in mental health screening and response) within a workplace. This small group of employees provide support to fellow employees and direct colleagues to professional mental health services. (Glozier, N, WorkSafe NSW, 2017, HeadsUp 2015).
- Ensuring services have a clear scope of practice and clear referral pathways when a client presents with issues that are outside a service's scope of practice.

Funding Arrangements

What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future? Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements? How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government? Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?

Cumulative factors are driving growth in mental health expenditure in Australia; poverty, isolation, urbanisation, discrimination, social media, poor nutrition, climate change, displacement and war. These

are issues entrenched in the unequal distribution of power, money and resources. Global issues have a local impact. For example, the way in which the media report on population groups and key issues can directly influence stigma, hate and self-esteem, through prominence and validation of discrimination.

Climate change is an emerging driver for shifts in mental health service demand. Changes in weather dramatically influence individual and community wellbeing. Natural disasters greatly impact productivity and employment, increase living expenses, restrict access to affordable and nutritious food, and impinge on people's basic human rights. These pressures and stress can have negative influences on the mental wellbeing of a person, for example the loss of a home due to fire can trigger the onset of depression.

Shifting the proportion of mental health expenditure from treatment to prevention can only be achieved with funding changes. For example, increasing health promotion funding, introducing diverse and flexible funding to facilitate service providers in delivering prevention and early intervention based strategies, outcome based funding for acute, sub-acute and community services and incentive based funding models.

Service funding arrangements differ according to the service or sector. The challenge faced is that the funding incentive is often based on episodic care rather than client outcomes and sustained client wellbeing. Achieving optimal wellbeing and sustained functioning for a client needs to be valued over seeing a client for five visits or ten visits. Episodic service models that exist in alcohol and other drug services provide capped sessions with case management, which provides the wrap-around support to address underlying determinants. Although, gambling services have a counselling model that allows clients to be seen over a longer period but are unable to provide case management support due to funding limitations. The majority of gambling clients who present have a co-occurring issue with (but not limited to) family violence, drug and alcohol misuse, housing stress and/or employment concerns.

Inconsistency in care provided depends on where a person enters the health system, and this can alter the outcomes achieved short and long term for the individual and their respective dependents and/or carer/s.

Episodic funding models constrain service provider capacity, restricting their work to providing intervention and treatment services to clients. Mental health practitioners have insights and expertise to inform prevention work and relevant skills to deliver prevention initiatives in collaboration with health promotion and public health practitioners. Where funding models are output-based, incorporating financial incentives for client outcomes could increase capacity for upstream prevention efforts and innovative solutions to this complex and wicked problem.

Despite population growth and strong economic evidence that prevention is effective State-funded Integrated Health Promotion funding to Community Health Services has not increased since the funding cuts that were experienced in 2011 and the introduction of prevention based funding has not been included in service delivery funding models.

Community mental health promotion and prevention programs lack financial resources and specialised expertise to undertake comprehensive evaluations of actions, and for the sustainability of effective initiatives. The sustainability of interventions is challenged with the lack of prevention funding growth. Organisations are pushed to close effective and well established work due to emerging issues or new funding opportunities. Sustaining effective program delivery and evaluation that continues to meet a

need, requires growth funding in prevention. Grant funds from Governments, philanthropic organisations and not-for-profit bodies are limiting their funds to innovative and new work, not sustaining or evolving existing work. Funders are not funding salaries or wages, causing organisations to choose between sustainability of existing work and new work. In some cases these strict guidelines can directly hinder the implementation of self-determination principles for example, employing people with a lived experience or peers or mentors to co-deliver initiatives. Growth funding in Integrated Health Promotion and new funding rounds that sustain effective, established and successful interventions in the community are needed, alongside new funding streams for innovative solutions and new work.

Providing incentives to corporate and public organisations to embed inclusive environments and non-discriminatory practices could support clients who are experiencing mental health issues. For example, unconscious bias training and practices, flexible work arrangements, cross-cultural training, rainbow tick accreditation and achievement of equal pay for all staff working in the same role. Funding for training employees outside the health sector is required to effect population change.

Implementing funding incentives to non-health sectors to respond to the protective factors for mental health could enable collaborative efforts between non-health and health sectors to improve population mental health. For example, financial incentives could enable VicRoads to produce road signs that include native Aboriginal names on town signs and the Department of Education to embed cross-cultural training and mental health training in education curriculum. Making health everybody's business and employing a 'Health In All' policies framework at a State and Local Government level could allow incentive based funding to better support grass root and bottom-up action.

Monitoring and Reporting

If multi-disciplinary mental health teams were implemented across Victoria that utilised one shared data management system this could increase the ability to track short, mid and long term outcomes for clients, identify social and economic outcomes as well as mental health outcomes achieved, reduce duplication in effort, limit clients presenting to multiple services for treatment, and track if clients are re-entering the service and at what point. A data monitoring system such as this would require considerable funding, auto-mated collation and analysis features, alarms for emerging trends and capacity for new inclusions as the mental health service and health service systems evolve.

The inclusion of client service reviews built in to the service model could improve understanding the significant outcomes received by the client, where enhancements or changes to the system could occur and trigger client oriented innovation. To identify targets, measures and incentives all stakeholders including those directly impacted by the system need to participate.

Currently most reporting mechanisms rely on quantitative data only, meaning that a lot of the narrative around what is and what is not working in the system is omitted. For example, those services who close cases to attain targets are recorded and disseminated to funding bodies, but not necessarily matched to the families they leave unsupported.

Integration between acute, sub-acute and community data management system could enrich the evidence, identify systemic barriers, enhance the transition from one service tier to another, enable full monitoring of client risks and assist with real-time monitoring of trial interventions.

More recent tenders of mental health support models appear to be rolling out with newer data supports that do not integrate with existing systems. These new tender opportunities bring with them data reporting, administration and client management systems that are new and not at all able to integrate into systems already in place for services. Newer funding models need to ensure that their supporting client management and data reporting systems integrate into a service's current systems.

References

Ashfield, Dr J, Macdonald, Prof J, Francis, A Prof A, Smith, A Prof A. (2017). A Situational Approach to Mental Health Literacy in Australia; Redefining Mental Health Literacy to Empower Communities for Preventative Mental Health. Retrieved from:

https://www.westernsydney.edu.au/_data/assets/pdf_file/0019/1308223/Mental_Health_Literacy_Paper_web.pdf

Beyond Blue. (2018). Be You Evidence Summary. Retrieved from: <https://beyou.edu.au>

Beyond Blue. (2019). Factors affecting LGBTI people. Retrieved from:

<https://www.beyondblue.org.au/who-does-it-affect/lesbian-gay-bi-trans-and-intersex-lgbti-people/factors-affecting-lgbti-people>

Blackdog Institute. (2017). Facts & figures about mental health. Retrieved from:

https://www.blackdoginstitute.org.au/docs/default-source/factsheets/facts_figures.pdf?sfvrsn=8

Commonwealth Government of Australia. (2018). Gender pay gap. Retrieved from:

<https://www.wgea.gov.au/topics/gender-pay-gap>

Connect Health and Community. (2017). Emotion Wellbeing Group Evaluation Report.

Department of Health. (2013). Improving men's health and wellbeing- Resource: data and evidence. Retrieved from: <https://www2.health.vic.gov.au>

Early Action-Queensland Mental health Promotion prevention and Early Intervention Action Plan 2015-17

Ellingsaeter, Dr. A. (2012). Cash for Childcare – Experiences from Finland, Norway and Sweden.

Retrieved from: <http://library.fes.de/pdf-files/id/09079.pdf>

Everymind. (2017). Prevention First Framework: A Prevention and Promotion Framework for Mental Health. Retrieved: <http://s3-ap-southeast-2.amazonaws.com/everymind/assets/Uploads/EM-0026-Prevention-First-Framework.pdf>

European Commission. (2014). Tackling the gender pay gap in the European Union. Retrieved from:

http://ec.europa.eu/justice/gender-equality/files/gender_pay_gap/140319_gpg_en.pdf

HeadsUp. (n.d). Nine attributes of a healthy workplace. Retrieved from:

https://www.headsup.org.au/healthy-workplaces/what-is-a-mentally-workplace/9-attributes-of-a-healthy-workplace?&gclid=EAIaIQobChMI8J-0wLua4QIVgoRwCh1iQQNYEAYASAAEgLXdPD_BwE

HeadsUp (n.d). Good Practice framework for mental health and wellbeing in first responder

organisations. Retrieved from: https://www.headsup.org.au/docs/default-source/resources/good-practice-guide-first-responders_bl1675_acc_std.pdf?sfvrsn=e4b02c4d_8

HeadsUp. (2014). Developing a mentally healthy workplace: A review of the literature. Retrieved from: https://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_final-november-2014.pdf?sfvrsn=8

Hidaka, B. (2012). Depression as a disease of modernity: explanations for increasing prevalence. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330161/>

Glozier, Professor, N. (2017). Review of Evidence of Interventions to reduce mental ill-health in the workplace. WorkSafe NSW. Retrieved from: https://www.safework.nsw.gov.au/_data/assets/pdf_file/0008/360449/SW09006-0518-418530-Review-of-Evidence-of-Interventions-to-Reduce-Mental....pdf

LaMontagne, A., Martin, A., Page, K., Reavlet, N., Noblet, A., Milner, A., Keegal, T., Smith, P. (2014). Workplace mental health: developing an integrated intervention approach. *Journal of BMC Psychiatry*, 14, 131. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4024273/>

Miller, S. (2016). Evaluation of the Australian Men's Shed Association – Summary Report. Retrieved from: <https://mensshed.org/about-amsa/reports/amsa-evaluation/>

Min, J, Uk, C, Lee, Chul. (2013). Mental health Promotion and Illness prevention: A Challenge for Psychiatrists. *Department of Psychiatry, Journal of Psychology of Investigation*, 10 (4), 307-316. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3902147/>

Mir, E; Novas C. (2019). Social Media and Adolescents' and Young Adults' Mental Health. Retrieved from: <http://www.center4research.org/social-media-affects-mental-health/>

Organisation for Economic Cooperation and Development. (2017). Parental Leave. Retrieved from: https://www.oecd.org/els/soc/PF2_1_Parental_leave_systems.pdf

Parliament of Victoria. (2018). The Cost of Living: An Explainer. Retrieved from: <https://www.parliament.vic.gov.au/publications/research-papers/send/36-research-papers/13860-the-cost-of-living-an-explainer>

Queensland Government and the Queensland Mental Health Commission. (2015). Early Action, Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17. Retrieved from: https://www.qmhc.qld.gov.au/sites/default/files/wp-content/uploads/2015/10/QMHC-PPEI-ACTION-PLAN_WEB.pdf

Roberston, S, White, A. Gough, B. Robinson, M. Seims, A. Raine, G. Hanna, E. (2015). Promoting Mental Health in Men and Boys: What Works? Centre of men's Health, Leeds Beckett University, Leeds. Retrieved from: http://eprints.leedsbeckett.ac.uk/1508/1/Promoting_MentalHealth_Wellbeing_FINAL.pdf

Taylor, E, Moxham, L, Perlman, D, Patterson, C, Brighton, R. (2016). Self-determination in the context of mental health recovery. *Australian Nursing and Midwifery Journal*, 23 (10), 41-4.

Retrieved from:

<https://pdfs.semanticscholar.org/714a/4f0f06595e78f0116969860adb8532b1abb.pdf>

VicHealth. (2017). Evidence review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents. Retrieved from:

https://www.vichealth.vic.gov.au/~/_/media/resourcecentre/publicationsandresources/health%20inequalities/fair%20foundations/full%20reviews/healthequity_mental-wellbeing-evidence-review.pdf?la=en

Wilson, Nathan J; Cordier, Reinie. (2013). A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and wellbeing. Retrieved from:

<https://www.ncbi.nlm.nih.gov/pubmed/23343146>

WHO. (2010). WHO Healthy Workplace Framework and Model: Background and Supporting Literature and Practice. Retrieved from:

https://www.who.int/occupational_health/healthy_workplace_framework.pdf

WHO. (2005). Prevention of Mental Disorders: Effective Interventions and Policy Options. Retrieved from: https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

Statistics Iceland. (2017). The adjusted gender pay gap around 16%. Retrieved from:

<https://www.statice.is/publications/news-archive/wages-and-income/unadjusted-gender-pay-gap-2016/>

United Nations Human Rights, Office of the High Commission. (2019). Iceland leads the way on closing the gender pay gap, UN experts say. Retrieved from:

<https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=22594&LangID=E>

Appendix

Consumer interviews

Connect Health & Community conducted interviews with current clients, carers and consumers. A couple have been documented in detail below, if you wish to learn more we have voice recordings and detailed notes from additional consultations.

A focus group conducted with older female clients, the key issues were:

1. Challenges in navigating the health system and a lack of knowledge of appropriate services is a significant issue.

Not knowing what services provide directly impacts levels of confidence to access services. There is no central directory that has search functions to assist with navigating and some services ask you to contact them yet provide no details to call. Confusion surrounding the difference between services, charities and not-for-profit organisations and who to go too was raised, along with sometimes conflicting messaging and misinformation.

Those interviewed reported better community support to help service navigation and an improved easy to use services directory would assist them in accessing services for themselves and others.

There was a case study provided by one respondent who had sadly lost their granddaughter (27 y.o) to suicide in October 2018. The granddaughter had attempted suicide in early 2018 and was hospitalised, then received ongoing support via home outreach visits. The grandmother and the mother wanted to seek support for themselves and were unable to access anything despite speaking with the service providing the granddaughter with counselling. Further to this the mother was unable to identify an alternate service for the granddaughter who had reported that the service was not engaging and there were issues regarding privacy as she could hear other conversations occurring with workers.

2. Stigma around mental ill-health was raised and the impact was people felt unable to access services or were not wanting to acknowledge problems.

Beliefs in society that people can pull themselves out of their mental health issues results in the perception of blame and guilt brought on yourself and hinders your ability to access services. Action to destigmatise mental health and changing community attitudes and beliefs regarding seeking help for mental ill-health earlier was suggested as a solution.

3. A lack of alternative mental health support, that is client centered, was identified as an issue. It was raised that counselling was not the type of support these respondents would like to access and in some cases they would not access help. Alternative approaches such as art therapy and activity based support would better engage and support these clients. They reported issues with the funding model in that organisations had capped number of visits, which was not always conducive to their wellbeing. They also described issues with having to tell their story multiple times and the fatigue felt when they ended up at the wrong service and had to change service providers.

Interview with an adult mother, of a son with a mental health illness.

The most important thing would have been education. I wish I was educated about my son, around schizophrenia and drug use and what to expect would be normal for a boy like this and how to protect myself. What is of confusion and turmoil about what to do with my son.

Context: Son was in and out of hospital for a long period of time.

When I went to a Hospital it was a terrible experience. Son was in white clothes (wrap around shirt) with his buttock exposed with no shoes and his face was bruised – unexplained bruising, which were from too much legal drugs given and he fell and hit himself. I wasn't prepared for what I saw. It was so shocking and traumatic to see my son in this way. I wish someone could have taken the time to explain to me about my son and educate me and give me information and for someone to communicate with me. When my son was released from hospital, nobody told me anything. My son was discharged into my care without them having ask me or provide me with any formal support and I had no information on how to protect myself. I would have liked to have been part of discussions and case conferences with doctors involved while my son was in hospital and I would also liked to be part of the discharge plan. Help and support was never offered. There was no consistency with psychiatrists and I overheard a psychiatric nurse say that they were wasting their time with my family. My son absconded from the hospital on a number of occasions – there needs to be better security and supervision and they were under-staffed. My son had access to illegal drugs and to alcohol while in the hospital and was having sex with other patients in the hospital. A nurse told me this information and my son also told me this information. Being in a hospital, I thought my son was in a safe and protected place.

At the time the son was at Hospital, the client (interviewee) was coming in to Connect Health & Community for dental and client asked if there was counselling service offered. At this time, I felt like I was inside a dark tunnel and I felt claustrophobic, stuck, like I was in a dark hole.

Experience at Connect Health:

Client has found the experience here very helpful; mainly the consistency from counselling and dietician. Client said that she felt very ashamed, embarrassed and not accepted, and that Connect Health gave her a safe place to heal. Client said she is feeling more accepting of reality and of her son's reality. This was the place where I opened up about my own big secrets about bulimia and sexual abuse. It was the one place where I did trust and I was consistently accepted and not judged. As client did not have to pay for service, she was able to access the support she needed as she was financially stretched.