

**Submission to:**

**Productivity Commission draft  
report into mental health**

**January 2020**

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## About cohealth

cohealth is one of Victoria's largest community health services, operating across nine local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

A primary health service, cohealth provides integrated medical, dental, allied health, mental health and community support services. 950 staff over 34 sites provide these services, work directly with communities to understand their needs and develop responses, and deliver programs promoting community health and wellbeing.

Our service delivery model priorities people who experience social disadvantage and are consequently marginalised from mainstream health and other services – people who have multiple health conditions, have a disability, experience homelessness and unstable housing, those engaged in the criminal justice system, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs and LGBTIQ communities.

cohealth has lengthy experience providing responses to people living with mental ill health. Our work is person centred and based on a recovery framework and strength-based approach. Our services to people experiencing mental health issues have recently included mental health nursing, individual support, outreach services, mentoring, residential programs, homeless outreach, and complex care coordination. We have a particular focus on providing mental health support that takes account of the social determinants of mental health to ensure support is integrated with physical health care and social support programs, such as housing, employment and family support, and those aimed at reducing social isolation. Recognising that people with multiple and complex needs face greater barriers to accessing services and supports, along with health and social disadvantage, cohealth prioritises working with these people to maximise their mental and physical health and wellbeing outcomes. In response to the significant unmet needs of people with mental illness who are completing corrections orders we have also established a forensic mental health service as part of the overall community health service offering.

cohealth also recognises that health – including mental health - is affected by many factors including social inclusion and participation, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community to design our services, and deliver advocacy, health promotion and education activities to improve health and connectedness.

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## Response to the Draft Report

cohealth welcomes the opportunity to provide feedback on the Draft Report on Mental Health. cohealth provided a submission to the initial consultation round<sup>1</sup> and is reassured that the Commission has provided such as comprehensive set of recommendations to improve the mental health of Australians.

The breadth of recommendations the Commission has developed is commendable, from prevention, early intervention, psychosocial support and clinical services to the way sectors beyond the health system, such as employment, justice, housing and income support impact on mental health.

As a provider of community based mental health services to people who experience disadvantage and marginalisation, we are particularly pleased about the draft recommendations that:

- All Australians should have access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate (Draft recommendation [DR] 5.2)
- Guarantee continuity of psycho-social supports for all who need them (DR 12.2)
- Funding for psycho-social support services be extended to a minimum of five years (DR 12.1)
- All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them (DR 10.4)
- Governments should strengthen the peer workforce (DR 11.4)
- State and Territory Governments commit to no exits from institutional or corrective care into homelessness (DR 15.2)
- Housing and homelessness services should have the capacity to increase support for people with mental illness to find and maintain housing (DR 15.2)
- Stigma reduction strategies should be developed for the community and health professionals (DR 20.1)

cohealth is particularly reassured that the Commission sees the consumer, and those who care for them, to be at the heart of all care, and the clear focus of mental health system and responses, both at the individual and system level.<sup>2</sup>

Nonetheless, we suggest that improvements in the mental health of Australians would be larger and more sustainable if key areas in the Draft Report are strengthened.

### 1. Addressing the structural causes of poor mental health (appendix 1)

Key to improving the mental health of our community, and thereby improving social and economic participation, is actively addressing the broader social, economic and environmental conditions in which people live - the social determinants of health. cohealth acknowledges that while a range of factors contribute to mental ill health

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<sup>1</sup> Submission 231 <https://www.pc.gov.au/inquiries/current/mental-health/submissions>

<sup>2</sup> Prof. Stephen King, Presiding Commissioner, 2019 Grace Groom Memorial Oration <https://www.youtube.com/watch?v=segut3xkePY>

and illness, addressing the structural causes and contributors will significantly lessen the burden of mental illness on individuals, society, and the health and social support systems.

While the Draft Report acknowledges the importance of the social determinants of health<sup>3</sup> we are deeply concerned that their role in **causing** mental ill health has not been given the attention it deserves. If we are serious about improving the mental health of all Australians and preventing mental illness, we must address **all the causes**, rather than responding only when someone's mental health has declined.

The Draft Report commences by stating 'This inquiry is about the mental health and wellbeing of Australia's population, the prevention and early detection of mental illness, and treatment of those who have a mental illness' (p4). Prevention must include having a society where all feel valued, included and respected, and where policy decisions contribute to wellbeing rather than to mental ill health.

Key social determinates that impact on mental health and wellbeing were outlined in our original submission and are included as Appendix 1 to this submission. In particular we cannot emphasis strongly enough how important the following actions are:

#### **a. Reducing Poverty**

Low socio-economic status is a key underlying factor common to many people experiencing health disadvantage and lies at the heart of health inequality. Poverty can be both a cause and consequence of poor mental health.

As such, the extreme level of poverty experienced by people reliant on income support payments, particularly Newstart Allowance, should be a serious concern for everyone working towards improving mental health in Australia. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to social isolation and marginalisation.

The Draft Report claims, in section 14.5, to consider '...how the current suite of income support payments can meet the needs of people with a mental illness.'<sup>4</sup> In doing so it relates accounts from Newstart recipients describing how they struggle to pay basic bills to live and to afford treatment. However, it then goes on to state: 'The issue of adequacy for these payments relates to all recipients, not just people with mental illness, and is beyond the scope of an inquiry focussed on mental health.'<sup>5</sup>

This reluctance to address the issue of inadequate income support payments is deeply disappointing. People on Newstart Allowance have poorer mental health, and, as the Commission acknowledges, the low rate of Newstart Allowance exacerbates existing conditions and is so low that people are unable to afford treatment. A recent study by Monash University found that Newstart recipients were **6.8 times more likely to rate their health as poor** when compared to wage earners.<sup>6</sup>

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<sup>3</sup> For example, section 1.2 What affects Australians' mental health and wellbeing?

<sup>4</sup> Productivity Commission 2019, *Mental Health*, Draft Report, Canberra, p528

<sup>5</sup> Productivity Commission 2019, *Mental Health*, Draft Report, Canberra, p529

<sup>6</sup> Collie A, Sheehan L and McAllister A. The Health of Disability Support Pension and Newstart Allowance Recipients: Analysis of National Health Survey Data. Insurance Work and Health Group, School of Public Health and Preventive Medicine, Monash University (2019) <https://www.dspstudy.com/dsp-health-study>

The study found that nearly half (48.6%) of Newstart recipients reported having mental and behavioural problems, significantly higher than the 21% of wage earners.

The study report concludes that 'Actions that reduce the rate of poverty and serious financial stress amongst DSP and NSA recipients are thus likely to have a net positive impact on health.'<sup>7</sup>

The mental health of Australians cannot be improved if key contributors to the mental health of the poorest of our citizens - poverty and low rates of income support payments - continue to be ignored.

cohealth urges the Commission to recognise the detrimental impact such a low rate of Newstart Allowance has on mental health and recommend that the Federal Government act to increase the rate as a matter of urgency.

## **b. Housing**

The Draft Report recognises that 'Housing is a fundamental contributor to preventing poor mental health and promoting recovery for people with mental illness.'<sup>8</sup> The negative impacts of homelessness on physical and mental health are well recognised, including depression and other mental health problems.<sup>9</sup> Box 15.2 of the Draft Report - *Housing issues can contribute to poor mental health* – describes the ways that various ways that housing-related issues can contribute to poor mental health.<sup>10</sup>

However, despite this knowledge, the Draft Report then goes on to only consider housing supports for people with mental illness. While critically important – and we support the recommendations in this area – we urge the Productivity Commission to recognise the need to address housing stress brought on by the lack of affordable housing. Increasing the supply of social and affordable housing is a key means to prevent the poor mental health that results from poor and precarious housing. 500,000 new social and affordable homes are needed by 2026 to meet the current shortfall in these homes.<sup>11</sup>

## **c. Investment in approaches that promote social inclusion and cohesion, including anti-racism programs.**

The Draft Report rightly recognises the need for continuing action to address the stigma about mental illness that is still too common. However, stigma experienced about characteristics other than mental illness, along with discrimination and racism, are all contributors to poor mental health. Addressing the stigma, racism and discrimination that drives exclusion and has such a detrimental impact on mental wellbeing will contribute to improved health across the community.

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<sup>7</sup> Collie A, Sheehan L and McAllister A. The Health of Disability Support Pension and Newstart Allowance Recipients: Analysis of National Health Survey Data. Insurance Work and Health Group, School of Public Health and Preventive Medicine, Monash University (2019) <https://www.dspstudy.com/dsp-health-study>

<sup>8</sup> Productivity Commission 2019, *Mental Health*, Draft Report, Canberra, p541

<sup>9</sup> <http://www.nwhn.net.au/Health-Homelessness.aspx>

<sup>10</sup> Productivity Commission 2019, *Mental Health*, Draft Report, Canberra, p545

<sup>11</sup> <https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/>

We urge the Productivity Commission to examine the ways in which racism, discrimination and stigma in all its forms contribute to mental health, and recommend responses that promote inclusion and cohesion.

#### d. Action on climate change

Climate change is already having, and will continue to have, a significant negative impact on people's health and is widely regarded as the biggest health threat of the 21<sup>st</sup> century.<sup>12</sup> Despite this, the Draft Report included no mention of climate change or its impact on mental health.

The mental health impacts of climate change are significant, as a team of researchers from Australia and Canada have described in a review of the evidence on the mental health impacts of climate change:<sup>13</sup>

'The expanding research literature on climate change and mental health includes increasing evidence that extreme weather events - which are more frequent, intense, and complex under a changing climate - can trigger post-traumatic stress disorder (PTSD), major depressive disorder (MDD), anxiety, depression, complicated grief, survivor guilt, vicarious trauma, recovery fatigue, substance abuse, and suicidal ideation. Incremental climate changes, such as rising temperatures, rising sea levels, and episodic drought, can change natural landscapes, disrupt food and water resources, change agricultural conditions, change land use and habitation, weaken infrastructure and give rise to financial and relationship stress, increase risks of violence and aggression, and displacement of entire communities. The overarching threats of a changing climate, can also incite despair and hopelessness as actions to address the "wicked problem" of climate change seem intangible or insignificant in comparison to the scale and magnitude of the threats.'

These impacts are disproportionately greater for marginalised and vulnerable communities.<sup>14</sup>

The extreme weather events of the summer of 2019/20 – bushfires and lengthy drought – will exact a huge toll on mental health and should serve as a warning that urgent action is required to reduce the threats posed by climate change and to adapt to these threats. We urge the Productivity Commission to seriously consider the impacts of climate change on mental health.

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<sup>12</sup> Psychologists for a Safe Climate, submission to the Royal Commission into Victoria's Mental Health System

<sup>13</sup> Hayes, K, Blashki, G, Wiseman, J, Burke, S & Reifels, L (2018) Climate Change and mental health: risks, impacts and priority actions. *International Journal of Mental Health Systems* 12:28  
<https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0210-6>

<sup>14</sup> Hayes, K, Blashki, G, Wiseman, J, Burke, S & Reifels, L (2018) Climate Change and mental health: risks, impacts and priority actions. *International Journal of Mental Health Systems* 12:28  
<https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0210-6>

## Recommendation 1:

**The Productivity Commission give greater consideration of the social determinants of mental health in the Inquiry, and urge the Government take action to address them, particularly:**

- **Reducing poverty through an urgent increase to Newstart Allowance**
- **Increasing social and affordable housing**
- **Action to reduce racism, stigma and discrimination, both overt and systemic**
- **Acknowledging the impact of climate change on mental health and taking urgent action to address climate change**

## 2. Investing in community-based mental health services

The Draft Report recognises the importance of providing mental health care in the community. Investing in community-based services will enable more people to receive support and care early and prevent their condition declining to the point where they are in crisis and needing acute care. This has clear personal and family support benefits, with improved health and people remaining more connected to family, work and social networks, along with financial savings through the reduced costs to the acute health system.

Our experience demonstrates that people with complex mental illness can live well in the community with the right support packages available to them. At the same time, community-based services are critical for the broader 'missing middle' – those who require more assistance than that provided by primary care but are not unwell enough for the acute services.

However, this support needs to be properly resourced. Many of the community-based services that have been available, primarily for those with more complex mental health needs, have recently closed as funding was transferred to the NDIS. Our initial submission, and those of other providers and individuals, describes the impact of these closures, specifically the loss of recovery-oriented psychosocial rehabilitation support. Unfortunately, the Draft Report has not made a specific recommendation to significantly expand community-based recovery and rehabilitation services. Without an explicit articulation of the need to expand such community-based care it will not be possible to ensure the integration of the medical approach to mental health with social care and support, and the level of community support necessary to support recovery.<sup>15</sup>

cohealth has identified the following models as examples of evidence and community based psychosocial support that meet the support needs people with mental illness require to remain well in the community and integrate mental and physical health care within a recovery-oriented approach.

Each of these approaches are well developed service models that are ready to be implemented that could be operated nationally in a comprehensive psychosocial approach for people living with mental illness. A brief description of each model is

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<sup>15</sup> Mental Health Australia (2019) Preliminary Analysis of the Productivity Commission Inquiry into Mental Health <https://mhaustralia.org/our-work/productivity-commission-inquiry>

provided here, full details are in the appendices.

### **a. Collaborative Recovery Model (appendix 2)**

The Collaborative Recovery Model (CRM), developed by the University of Wollongong Illawarra Institute for Mental Health, is a way of working which incorporates practices that have been shown to assist people living with an enduring mental illness. These include: psychosocial rehabilitation principles, Motivational Interviewing, the Stages of Change model, Resilience theory and Self-determination theory.

The CRM supports consumers to identify and clarify their goals and the issues that are most important to them. This process facilitates better care planning with the consumer which is more tailored to the individual and supports a multidisciplinary approach to care contributing to better outcomes for the consumer and family.

cohealth community mental health teams which use CRM are multi-disciplinary and include peer workers who use their lived experience of mental health in their work with consumers. Teams are experienced in community mental health, taking a multi-sector collaborative approach to delivery of services and working with clients with complex needs. Working closely with clinical mental health services and general practitioners, people's clinical needs are monitored to reduce mental health 'crisis' and reduce the need for hospitalisation when the fluctuations and episodic periods of ill health arise. Staff are trained in CRM, Recovery Star, coaching, trauma informed care and family inclusive practice.

The psychosocial and recovery supports provided in the cohealth programs using CRM include:

- Outreach to individuals
- Group activities
- Peer work
- Phone support or e-coaching
- Recovery support planning
- After hours support

### **b. Community Mental Health – a vision for integrated primary health and community mental health (appendix 3)**

cohealth has developed a model to address the needs of the increasing number of people not receiving the psychosocial support they need, address the poorer physical health of people with mental illness and to intervene early before acute, more costly care is required.

Comprehensive mental health care will be integrated into existing multidisciplinary allied health teams in our community health service.

The program is designed to work with people with a severe mental illness, complex support needs and a psychosocial disability who are not receiving the recovery-based psychosocial support they need to remain well in the community. It will also work with

those who have chronic or complex physical health care needs and need psychosocial support.

Building on our deep connection with local community, the model provides a place-based, accessible and holistic health response in the community – intervening earlier, responding more quickly and providing choice and control. The service will take the pressure off clinical mental health and acute health services, including emergency departments.

Multi-disciplinary teams will provide a same day response, care coordination, step up mental health support and a comprehensive range of mental health supports. These will include individual and group programs, secondary consultation, service coordination, family and carer support, counselling for low prevalence disorders and mental health support to the 60% of people with a chronic health condition who also have a mental health issue. Mental health focussed health management opportunities and health literacy activities will improve the poorer physical health experienced by people with mental illness.

Integration of mental health and physical health in the mainstream community health environment will deliver a more accessible service with improved health outcomes and address the needs for such care identified by the Draft Report.

### **c. Homeless Outreach Mental Health Service – HOMHS**

cohealth's HOMHS program was described in our original submission<sup>16</sup> and referenced in the Draft Report as an example of an outreach mental health and care coordination services (box 15.4 p584). To recap, cohealth is a key partner in the Homeless Outreach Mental Health Service (HOMHS), which responds to clients with intersecting homelessness and mental illness needs. HOMHS demonstrates the importance of multi-disciplinary teams working in partnership to provide integrated supports to consumers.

The service is located at the cohealth site in Melbourne's CBD (Central City Community Health Service) and offers intensive clinical and community mental health care and case management to people with severe and enduring mental illness and a history of chronic homelessness. cohealth, as the lead agency, partners with three agencies to deliver the program – Inner West Area Mental Health Service who provide clinical mental health services; McAuley Community Services for Women who have specialist skills in engaging the growing number of women experiencing homelessness; and Launch Housing who provide links to stable and affordable housing. The HOMHS interagency multidisciplinary team offers assessment, integrated clinical treatment, recovery support, housing support and care coordination, scaled in intensity to meet each client's needs, values and goals.

Through this interdisciplinary and multi-agency approach, HOMHS improves access for clients to mental health services, housing support – including stabilising housing - physical health care, and practical assistance. Examples of positive outcomes from the program include: 86% of clients who were placed in stable housing have maintained it

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<sup>16</sup> Submission 231 <https://www.pc.gov.au/inquiries/current/mental-health/submissions>

long term; 46% were linked to a GP where they previously weren't; and there was a 42% reduction in emergency department admissions<sup>17</sup>. The program's success in improving health and wellbeing lies in the intensive support provided to clients, combined with the joint clinical and community mental health supports and other support structures, including housing services.

**Recommendation 2:**

**Invest significantly in community-based early intervention and support services to re-orient the mental health system towards keeping people well and reducing the need for acute care.**

**This needs to include significant re-investment in community-based psychosocial rehabilitation, based on recovery-oriented practice, for those who need it.**

**Mental health care should be integrated with multidisciplinary physical health care and social support services. Community health services provide an ideal platform to provide these services.**

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<sup>17</sup> Liptrot, G, Pruden, D, Pollins A, Parkin, L & Alexander, D (2018) *Working together: Homeless Outreach Mental Health and Housing Service (HOMHS.)* Parity, Council to Homeless Persons Dec 2018

## Appendix 1: Social determinants of health<sup>18</sup>

(Excerpt from original cohealth submission – number 231 - to Productivity Commission Inquiry into Mental Health)

“Mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual solutions.”  
World Health Organization <sup>19</sup>

The broader social, economic and environmental structures in which people live – the social determinants of health – have an overwhelming influence on the health of individuals and communities. The unequal distribution of income and education, coupled with changing employment opportunities, reduced social expenditure and an increase in divisive narratives, means that for many, quality of life is deteriorating. Life is becoming harder for the communities we work with.

In order to change this cohealth supports a ‘health in all policies’ approach – where governments consider the health impacts of all policy decisions, and proactively work to address the underlying drivers of ill-health, including:

- socio-economic inequalities
- stigma and discrimination
- availability of affordable, secure housing
- social isolation and loneliness

These social determinants underlie the experience of health conditions, including mental ill health. Evidence increasingly demonstrates the significant impact on mental health of poverty, inadequate housing, racism, stigma, discrimination and experiences of violence and trauma. For this inquiry to improve the mental health of Australians, and the responses to those with mental ill health, it is essential that that Productivity Commission gives careful consideration of these matters. Any reforms aimed at improving the mental health of the nation, and responses to people who experience mental ill health, that fail to address the social determinants of health will not be as effective as they could be.

At the same time, mental health gains made through clinical treatment and community-based support will not be as effective or sustainable if the circumstances people are living in do not support recovery, such as poverty, homelessness and family violence. Concerted and comprehensive policy responses are required to respond to these matters.

We cannot view mental health as separate from the whole of society we live in, including – and particularly – the values and social structures and policies that underpin society.

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<sup>18</sup> The conditions of daily life – “the circumstances in which people are born, grow, live, work and age – and the structural conditions in a society, which lead to unequal living conditions and affect the chances of living a healthy life”. <http://apo.org.au/node/55699>

<sup>19</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0012/100821/E92227.pdf](http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf)

Social determinants affecting mental health include:

## 1. Poverty

Low socio-economic status is the key underlying factor common to almost all people experiencing health disadvantage and lies at the heart of health inequality. The impacts of low income are exacerbated by expensive housing, insecure employment, unemployment and underemployment; and location that is removed from services, jobs and health services.

Poverty can be both a determinant and a consequence of poor mental health, and the relationship between low economic status and elevated incidence and prevalence of mental illness is now well recognised.<sup>20</sup> Studies throughout the world have demonstrated an inverse relationship between mental illness and social class<sup>21</sup> – that people on lower incomes have poorer mental health than those on higher incomes.

Socio-economic disadvantage is clearly associated with poorer mental health. Barriers to opportunities such as work and education can lead to poor social connection, increased social isolation and a lack of attachment to communities. Social exclusion, and the stress of living on or under the poverty line have a negative effect on mental health.<sup>22</sup>

Meeting health costs is a struggle for people on low income, with the costs of services and prescriptions harder to meet. It is also common for people on low incomes to delay seeking medical care due to cost. Health conditions are then more severe when treatment is sought, with corresponding greater impact on the individual. If you are unable to get to a service, or pay for it, then conditions go untreated. Mental health conditions are made more chronic and longer term when they're not treated.<sup>23</sup>

Research has now found that poverty also has a significant influence on the development of children's brains. Disturbingly it has found that disadvantage begins at birth, is intergenerational and children from poorer socio-economic backgrounds are at greater risk of mental illness than those from more affluent circumstances.<sup>24</sup>

As such, the extreme level of poverty experienced by people reliant on income support payments, particularly Newstart Allowance, is a serious concern for mental wellbeing. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to social isolation and marginalisation. For

<sup>20</sup> [https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty\\_social\\_inequality\\_and\\_mental\\_health.pdf](https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf)

<sup>21</sup> [https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty\\_social\\_inequality\\_and\\_mental\\_health.pdf](https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf)

<sup>22</sup> <https://www.sbs.com.au/topics/life/health/article/2017/11/07/surprising-link-between-mental-illness-and-poverty>

<sup>23</sup> <https://www.sbs.com.au/topics/life/health/article/2017/11/07/surprising-link-between-mental-illness-and-poverty>

<sup>24</sup> <https://www.sbs.com.au/topics/life/culture/article/2017/11/24/how-much-do-you-know-about-science-poverty?cid=inbody:the-surprising-link-between-mental-illness-and-poverty>

example, in a study examining the impact of 'Welfare to Work' policies on single mothers, the findings clearly showed that those parents receiving Newstart Allowance showed higher levels of mental health problems, compared with parents with continued eligibility for Parenting Payment Single, which is paid at a higher rate.<sup>25</sup>

There is now broad support – from business and industry groups, community sector, unions and civil society - for the urgent increase in Newstart payment. cohealth strongly supports these calls, recognising the benefits to the physical and mental wellbeing of individuals and families that will flow from such an overdue measure.

## 2. Punitive welfare systems

The last 15 years have seen increasingly punitive and inflexible requirements placed on recipients of income support payments. Based on the erroneous assumption that unemployed people will not seek work, or manage their finances and lives, responsibly and independently, an increasing array of requirements have been imposed on them. Compulsory income management, ParentsNext, harsh sanctions regimes, unreasonable job search requirements, and proposals for random drug testing, all demonise and stigmatise people, and cause significant stress.

Research is revealing the detrimental impact these approaches are having on the mental health of income support recipients. A major study in the UK has found that 'Welfare conditionality<sup>26</sup> was also reported as being associated with negative health outcomes including fear, anxiety and psychological distress, and is exacerbating existing health conditions, in particular in people with mental health issues.'<sup>27</sup>

Limitations placed on other forms of assistance can have unintended consequences on people with mental ill health. For example, if parents are unable to meet the activity test for the Federal Childcare Subsidy access to child care can be restricted. For people with mental illness this can make it particularly hard for them to participate in treatment or manage their own health. Reduced access to education and care can impact on children's wellbeing, through missing out on the developmental benefits of early childhood education.

## 3. Neoliberalism and individualism

Our culture has evolved to one that promotes individualism and materialism, yet this disconnection with each other and the community we live in is increasingly recognised as a major contributor to mental ill health. Studies have shown that materialism, for example, is associated with dissatisfaction, depression, anxiety and isolation.<sup>28</sup> The very social structure that we now live in has exacerbated levels of anxiety and depression.<sup>29</sup> As stress and insecurity play a significant role in mental ill health that it is not surprising that the increase in mental ill health has occurred at the same time as the dramatic rise in precarious and casualised work.

<sup>25</sup> <https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12304>

<sup>26</sup> The linking of welfare rights to specific obligations or patterns of behaviour

<sup>27</sup> <https://basicincome.org/news/2018/07/united-kingdom-study-suggests-that-welfare-conditionality-does-more-harm-than-good/>

<sup>28</sup> [https://www.richardeckersley.com.au/attachments/IJepi\\_culture\\_1.pdf](https://www.richardeckersley.com.au/attachments/IJepi_culture_1.pdf)

<sup>29</sup> <https://inthesetimes.com/article/20930/depressed-anxious-blame-neoliberalism>

Government policies – across all domains - must be cognisant of this link, and work towards enhancing community connectedness and a sense of belonging, rather than exacerbating isolation and marginalisation.

#### 4. Racism

There is now substantial evidence about the many health impacts on individuals of racism. As a recent Victorian Department of Health and Human Services report *Racism in Victoria and what it means for the health of Victorians* states:

“There is an abundance of high-quality scientific studies that show that racism is a key determinant of the health of Aboriginal Australians and other minority groups. This report shows that racism is harmful to the health of those who are its victims. Moreover, racism is not just harmful to mental health, it is also harmful to physical health.”<sup>30</sup>

Racism has a negative effect on health both directly and indirectly.

For individuals, the harmful effects of racism on mental health include conditions such as psychological distress, depression, anxiety, post-traumatic stress disorder, psychosis and substance abuse disorders.<sup>31</sup> We now also know that the harmful physical health effects of racism are just as significant, including cardiovascular disease, hypertension, adult-onset asthma, cancer and accelerated biological ageing. Racially motivated assaults of course have both physical and mental health consequences.

The impacts of racism go well beyond the individual. Alarming, there is now also evidence that maternal exposure to racism elicits a physiological stress response causing subtle but harmful effects on a foetus that can continue into adulthood.<sup>32</sup>

More broadly, systemic racism serves to maintain or exacerbate the unequal distribution of opportunity across ethnic groups through the way our systems and services are structured and delivered. As a result, people may not seek the support and services they need and are entitled to.

Racism reduces access to employment, housing and education, resulting in low socio-economic status<sup>33</sup>, and as socio-economic status declines, so does mental and physical health.

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<sup>30</sup> <https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria>

<sup>31</sup> <https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria>

<sup>32</sup> <https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria>

<sup>33</sup> <https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria>

## 5. Stigma and discrimination

Emerging evidence<sup>34</sup> indicates that stigma and discrimination are also fundamental causes of health inequalities. Stigma directly influences the physical and mental health outcomes of people with specific characteristics (eg their race, sexuality or gender identity, or particular illness). Stigma and discrimination also limits or disrupts access to the structural, interpersonal and psychological resources that could otherwise be used by individuals or communities to improve health. People experiencing stigma may not seek care if they perceive providers to be unwelcoming or unsafe. Health systems may not provide the same level of care to particular groups due to inappropriate assumptions made about their health and behaviour.

Actions to reduce racism, stigma and discrimination will improve the mental health of the community.

## 6. Inadequate Housing

Secure, adequate housing is fundamental to the wellbeing of individuals and families.

The negative impacts of homelessness on physical and mental health are well recognised, including depression and other mental health problems.<sup>35</sup> Not only does the experience of homelessness exacerbate existing mental illness, but it can also precipitate the deterioration of mental health. Precarious housing, including insecure tenure, poor quality housing and overcrowding also impacts on mental health, as does ongoing uncertainty and stress about ability to meet the costs of housing (rent or mortgage).<sup>36</sup>

Research has concluded that governments can improve the mental health of economically vulnerable populations through more supportive housing policies.<sup>37</sup> With current high housing costs, and more people experiencing homelessness, it is critical for mental health that governments of all levels take urgent action to increase the supply of affordable and social housing.

### Recommendation 3:

**The Productivity Commission include consideration of the social determinants of mental health in the Inquiry, and urge the Government take action to address them, particularly:**

- **Reduce poverty through an urgent increase to Newstart Allowance**
- **Remove punitive and confusing income support compliance regimes**
- **Move away from precarious and insecure employment arrangements**
- **Act to reduce racism, stigma and discrimination, both overt and systemic**
- **Increase social and affordable housing**

<sup>34</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/>

<sup>35</sup> <http://www.nwhn.net.au/Health-Homelessness.aspx>

<sup>36</sup> Mallett, S, et al (2011). Precarious housing and health inequalities: what are the links? Summary report. [https://www.vichealth.vic.gov.au/~media/resourcecentre/publicationsandresources/health%20inequalities/precarious%20housing/precarious%20housing\\_summary%20report\\_web.pdf?la=en](https://www.vichealth.vic.gov.au/~media/resourcecentre/publicationsandresources/health%20inequalities/precarious%20housing/precarious%20housing_summary%20report_web.pdf?la=en)

<sup>37</sup> Bentley, R et al (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, *Housing Studies*, 31:2, DOI: [10.1080/02673037.2015.1070796](https://doi.org/10.1080/02673037.2015.1070796)

## Appendix 2: The Collaborative Recovery Model

The Collaborative Recovery Model (CRM) developed by the University of Wollongong Illawarra Institute for Mental Health, is a way of working which incorporates practices that have been shown to assist people living with an enduring mental illness.

CRM is an evidence, strengths and values based coaching model, and person-centred approach, which is future oriented and focused on meaningful goal attainment for people living with mental illness. Considerable research and evaluation of the CRM and recovery has been undertaken and links to a range of peer reviewed journal articles, book chapters and other publications can be found

at: <https://documents.uow.edu.au/content/groups/public/@web/@health/@iimh/documents/doc/uow199478.pdf>

The CRM is also consistent with the values of the recovery movement and aligned with the domains of recovery-oriented practice and service delivery approaches outlined in various Australian governments' frameworks, such as *A national framework for recovery-oriented mental health services*<sup>38</sup> and the *Victorian Framework for recovery-oriented practice*<sup>39</sup>.

The CRM is a way of working which incorporates practices that have been shown to assist people living with an enduring mental illness, including: psychosocial rehabilitation principles, Motivational Interviewing, the Stages of Change model, Resilience theory and Self-determination theory. It is underpinned by positive psychology and the consumer participation movement.

The CRM takes a holistic approach, engaging not only with the client but also with their wider support system (family, caregivers and friends, support workers, etc.) in order to ensure they are effectively supported on their recovery journey. The CRM has two guiding principles and four components:

Principle 1 – *Recovery as an Individual Process*. Recovery is a unique and personal journey towards hope, meaning, identity and responsibility for self. The CRM focuses on increasing wellbeing rather than decreasing symptoms and aims to promote the processes of psychological recovery.

Principle 2 – *Collaboration and Autonomy Support*. The strength of the relationship that exists between an individual living with a mental illness and the people that are supporting them has a significant influence on mental health outcomes. The CRM focuses on the collaborative nature of this relationship, perceiving it as a working alliance which supports the autonomy of the person.

*Change Enhancement* - supporting the individual to explore their relationship to change and build confidence and capacity to engage in a change process. The model recognises that everyone is different, and that change is a very individual process.

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<sup>38</sup> <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>

<sup>39</sup> <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Framework-for-Recovery-oriented-Practice>

*Collaborative Strengths and Values Identification* – identifying and bringing into focus the personal strengths and values of the individual as they start to vision a life of meaning and purpose for themselves.

*Collaborative Visioning and Goal Striving* - setting goals to support the individual to further express their strengths and values in their day to day lives.

*Collaborative Action and Monitoring* - supports the realisation of goals through the development of action plans including the supports the person will need to achieve their goals.

The CRM supports consumers to identify and clarify their goals and the issues that are most important to them. This process facilitates better care planning with the consumer which is more tailored to the individual and supports a multidisciplinary approach to care contributing to better outcomes for the consumer and family.

Other evidence-based tools and practices are also used to support consumers, including the Recovery Star outcome measure. This is used with the consumer to support and measure their own progress and gives a picture of what is working and what needs to change, by focusing on the person rather than the problem. The Recovery Star is underpinned by the assumption that positive growth is a realistic goal and uses the Ladder of Change and domains linked to recovery: mental health, physical health, family relationships, quality of life, community and social connection, education, training and/or employment, and independence/social skills.

Currently cohealth community mental health, and a number of other mental health providers, offer a range of evidence-based recovery-oriented psychosocial programs, including residential and outreach programs, to consumers where the CRM approach is used as the overarching service model. This includes Prevention and Recovery Care programs (PARCs), Youth Residential Rehabilitation programs, Early intervention Psychosocial Support Response (EIPSR), adult residential program, Homeless Outreach Mental Health Service and outreach based Psychosocial Support Services for those not eligible for NDIS.

Community mental health teams are multi-disciplinary and include peer workers who use their lived experience of mental health in their work with consumers. Teams are experienced in community mental health, taking a multi-sector collaborative approach to delivery of services and working with clients with complex needs. Staff are trained in CRM, Recovery Star, coaching, trauma informed care and family inclusive practice.

As a service model example, our outreach-based Western Psychosocial Support Service (WPSS) and EIPSR teams take a stepped care approach and incorporate a tiered response by offering a brief, moderate or comprehensive response depending on client need and offering clients a range of evidence-based psychosocial and recovery support options. This graduated response supports client independence and self-efficacy while meeting demands and achieving throughput. This approach also supports clients to achieve sustainable outcomes with a step up, step down option by being able to respond to unexpected stressors or crisis or expedite re-engagement if needed.

The tiered response includes:

- Intake - covering eligibility, screening, initial needs and risk assessment and consent. Intake is predominantly a warm response by phone, however has face-to-face capacity if required. Intake is responsible for initial socio-demographic and other data collection as well as referrer liaison and feedback.
- Brief response – clients are allocated and engaged quickly to identify and prioritise goals, explore options and actions. Agreements, actions and review form the Brief response plan, including a finishing process. This response is offered for a period of four to eight-week engagement.
- Moderate (up to 6 months response) and Comprehensive (up to 12 months response) – clients are engaged to identify and prioritise goals, explore options and actions. A comprehensive assessment is started to gain a deep understanding of the client's needs, to assist them to understand what's important to them, what their strengths and values are, what they want to achieve and how they might achieve it. This process may continue whilst the provision of supports commences. Agreements, actions and review (3 monthly) form Recovery Support Plans. Coaching, the Recovery Star and CRM tools are used, roles and supporters identified, including the client identified natural support team and expected referrals. Integrated care needs and referral pathways are built into Recovery Support Plans and where required shared care plans are coordinated.

Family inclusive practice leads to carers' needs being identified early in the client engagement and appropriate supports offered or referrals made to address their needs. Where the client agrees carers and family are invited to be involved in the Recovery Support Plan.

Reviews focus on goal achievement and learning, addressing any barriers, strengthening enablers and confirming transition strategies.

Client caseloads can vary depending on the individual program and the demand and intensity of response required. For outreach clients, a general caseload would be approximately 25 clients per full time staff member.

The modalities of psychosocial and recovery supports provided include:

- One to one outreach
- Group activities
- Peer work
- Phone support or e-coaching
- Recovery Support planning
- After-hours support

### Sally's Story

Sally<sup>40</sup> joined the cohealth Youth Residential Rehabilitation (YRR) program at age 19. Child protection had been involved in Sally's life since she was approximately 9 years of age and she was removed from her family home by protective services at the age of 14. From the

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<sup>40</sup> Name changed

age of 14, Sally was placed in numerous residential and foster care arrangements, including a two week stay in secure welfare, before entering into homelessness at age 18. Immediately prior to engaging with the cohealth YRR program, Sally was in a youth refuge.

Sally has a history of childhood sexual and physical abuse, mental health concerns, impulsive suicidal behaviours, chronic suicidal ideation, deliberate self-harm and high-risk behaviours that led to criminal offences and a lengthy involvement with police. She has had multiple psychiatric admissions starting at the age 14 years and received a diagnosis of Borderline Personality Disorder and PTSD in 2013. Unmanaged trauma and mental health issues have led Sally to self-medicating with drugs and alcohol, and self-harming as a means of coping.

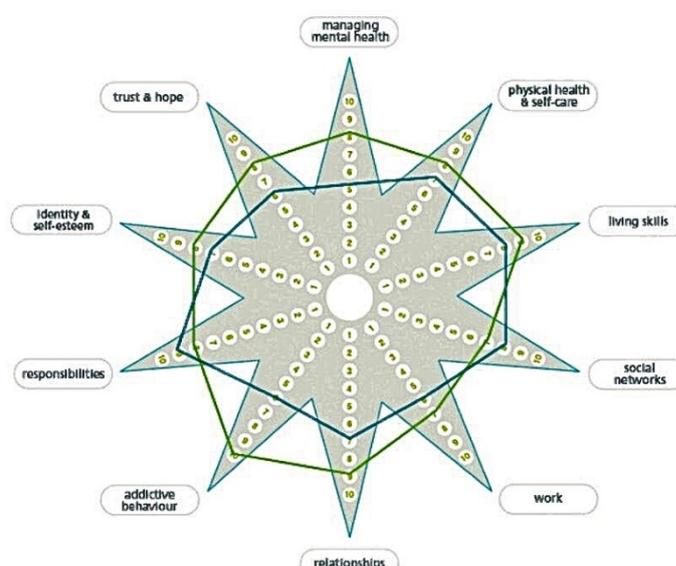
Sally has a history of refusing support from adults due to fear and mistrust and she did not receive clinical mental health support until she was 19 years of age.

Sally entered the cohealth YRR program in February 2015 and it took her some time to develop a trusting relationship with staff. Her lack of trust in others and diminished hope for recovery significantly impacted on her ability to engage in support whilst residing in the YRR program. However, with clear boundaries, consistency and persistence, she was able to begin to trust staff.

With the use of the CRM, a care team approach and a co-design model, Sally was able to lead her recovery and build on her strengths to better her situation. She developed a strong working relationship with her clinical mental health clinician, began to develop insight into her mental health and made a significant shift in the way her triggers and stressors were managed. Help-seeking and reflection became an important part of Sally's recovery and the ability to self-manage increased considerably. Psychiatric admissions reduced significantly, and she developed an awareness of her mental health and developed effective coping strategies to avoid deterioration in her mental state.

Sally completed the Recovery Star in March 2015 and again in March 2016 when she left the program. The scoring (see diagram) shows that Sally made significant progress in eight of the life domain areas. In particular, her self-assessment of the domains:

- 'Managing mental health' increased from 5 (Believing – I can make a difference) to 8 (Learning – I'm learning how to do this)'
- 'Addictive behaviour' increased from 5 (believing) to 10 (self-reliance)
- 'Trust and Hope', 'self-care', 'living skills', 'work' and 'relationships' all improved



These represent significant outcomes along the scale.

Sally successfully maintained attendance at school throughout the duration of her YRR stay and this commitment contributed to positive emotions, meaning and accomplishment for her. She has subsequently completed her studies upon leaving the YRR and has gone on to further studies.

Sally was transitioned out of the YRR program into long term independent housing. Her problematic criminal behaviours reduced significantly whilst in the YRR and although she continued to engage in substance use, it was in a much less harmful way.

## Appendix 3: Community Mental Health – a vision for integrated primary health and community mental health

### Overview

This proposal creates a new service model which integrates a comprehensive community mental health response in a primary health setting through existing community health multidisciplinary allied health teams (in a Victorian community health context). The model targets people with a severe mental illness, complex support needs and a psychosocial disability, including those who are ineligible for the NDIS. It will provide a placed based, accessible and holistic health response in the community – intervening earlier, responding quicker and providing choice and control.

This is an evidence-based model building on existing infrastructure and resources. It will support services, consumers and their families, providing service coordination and monitoring of system issues, ensuring that people do not fall through the gaps. It is a model which can readily adapt to the changing service environment.

The Community Mental Health (CMH) model team approach is flexible and can be broadened to include other at-risk populations including post-prison, Aboriginal and Torres Strait Islanders, vulnerable families and others.

A literature review identified three main (but very closely linked) models which are effective in improving mental health outcomes in the primary care environment and are consistently seen as more cost effective, responsive and accessible than stand-alone mental health services. These are:

1. Collaborative consumer driven care  
Care that is determined with and by consumers and delivered by providers from different specialities, disciplines or sectors working together to offer complementary services and mutual support.
2. Primary care and mental health integration  
Primary care and mental health integration. Its key feature is a 'behavioural health consultant (BHC)' who is embedded as a full-time member of the primary care team.
3. The Chronic Care Model (CCM)  
This model has been shown to improve medical and psychiatric outcomes for persons with mental illness in primary care settings with little or no net health care cost.

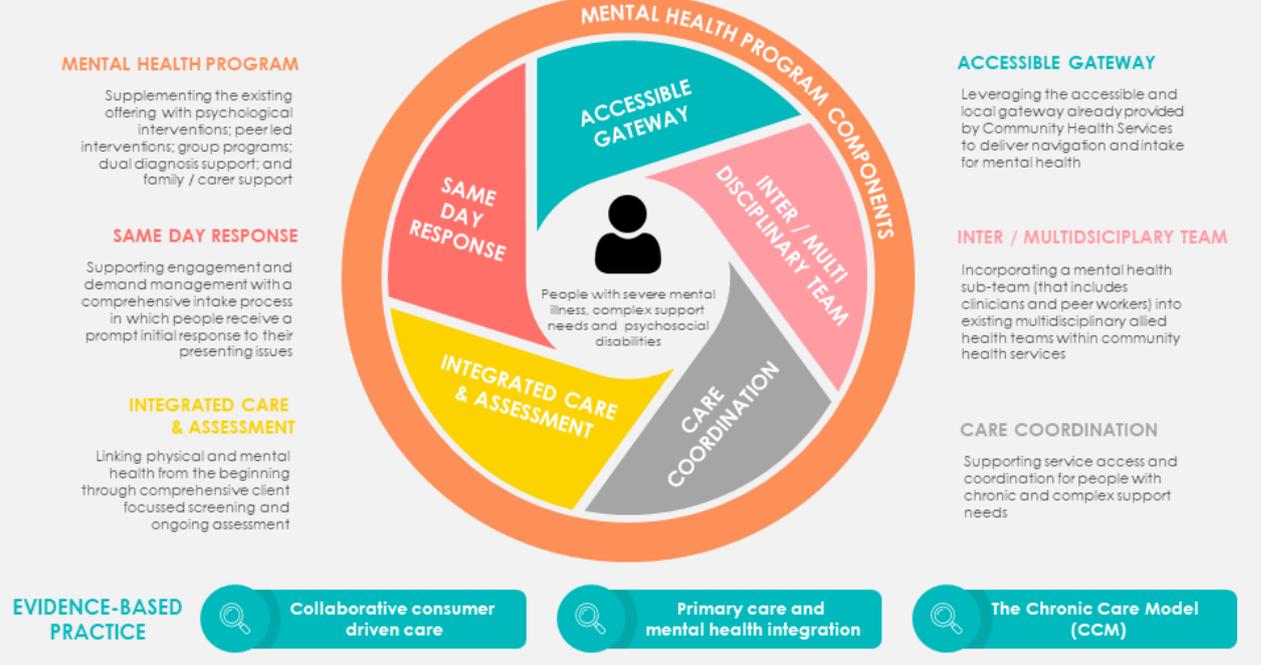
Attachment B outlines the evidence base for these models.

The key features of the CMH model build on government policy priorities, such as Victoria's *10-Year Mental Health Plan*, to ensure people can easily enter the primary health setting to have their broad range of needs identified quickly. Importantly their mental health needs are prioritised as part of an overall healthcare plan with specialist mental health workers as part of a multi-disciplinary team.

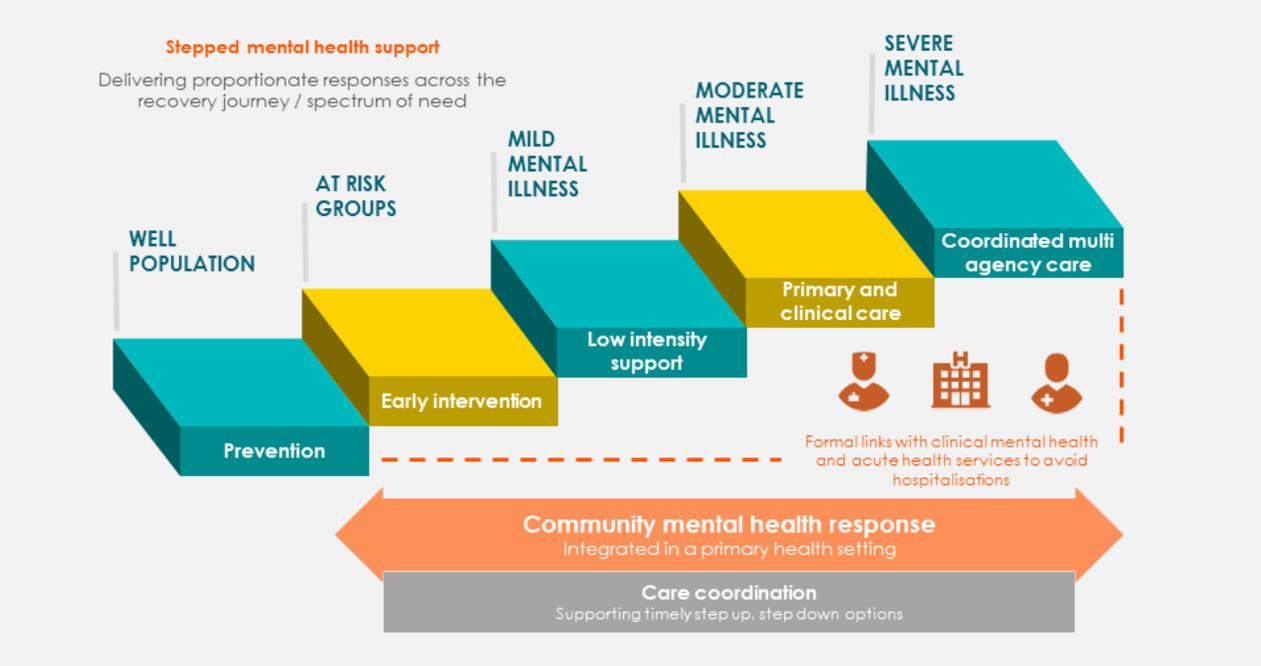
People living with serious mental health issues have a range of health conditions that, in our current system, are often not identified or treated. The new team model enables people to obtain support for their mental and general health recovery, with an emphasis on goal setting and coaching to achieve their identified goals. Over time this will improve people's health and reduce the burden on the health system as a whole.

Key features:	Key benefits:
<ul style="list-style-type: none"> <li>• Gateway to community based mental health services – service information, navigation and delivery</li> <li>• Client directed care</li> <li>• Integrated intake</li> <li>• Multidisciplinary allied health team with comprehensive mental health component</li> <li>• Care coordination</li> <li>• Stepped up and step down mental health care</li> <li>• Integrated care and assessment</li> <li>• Same day initial response</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced fragmentation and improved service navigation</li> <li>• Early intervention and reduced demand on acute services</li> <li>• Improved psychosocial outcomes for people with chronic and complex health needs</li> <li>• Improved physical health outcomes for people with a mental illness</li> <li>• Improved outcomes for people with complex support needs and chaotic presentations</li> <li>• Builds on skills and capacity of current workforce (including peer workforce) – supporting it through the period of change</li> <li>• Increased treatment and mental health support options for people with a mental illness, while retaining close links with clinical services – including for those people with severe mental illnesses and psychosocial disability who will be ineligible for the NDIS</li> <li>• Placed based service delivery – local and accessible</li> </ul>

**COMMUNITY MENTAL HEALTH MODEL**



**COMMUNITY MENTAL HEALTH MODEL**



## 1. Background

This service model has been developed to address the significant issues and gaps associated with access to mental health and primary health services identified by both the Productivity Commission Draft Report into Mental Health and the Royal Commission into Victoria's Mental Health System Interim Report.

There is a growing evidence base of the effectiveness of peer support models and consumer delivered services and a strong evidence base for the effectiveness of addressing mental health needs in primary care, rather than in specialised, mental health service environments. The track record for improving physical health outcomes and life expectancy for people with a mental illness has been appalling and there is a growing awareness that this must be addressed.<sup>41</sup>

This proposal offers a new way of thinking about mental health service delivery which provides benefits on a number of levels, including:

- Better service integration:
  - Builds on existing known and trusted infrastructure and service systems.
  - Removes the current separation of physical and mental health service delivery.
  - Service coordination function, service navigation and clear entry points to promote integration with Commonwealth services, clinical services, NDIS, other community services and GPs.
  - Integrates mental health and health service delivery – improving physical health outcomes for people with a mental illness and mental health outcomes for people with chronic disease.
- Uses a platform which can and will adapt to Medicare changes – thus maximising access to Medicare funding/ Primary Health Network commissioned services for people with a mental illness and complex needs and remain integrated with the rest of the service system.
- Minimises the impact of the transition to the NDIS – providing initially a safety net for people as they transition into the NDIS and ongoing mental health support for people who may not yet be eligible and/or need support to test their eligibility.
- Provides a mental health service response to those who have a severe mental illness and a disability but who will not be eligible for the NDIS.
- Provides specialised psychosocial support to complement the NDIS, clinical mental health services and Medicare services.
- Builds on the capacity of the current mental health workforce (including the peer workforce) – maximising retention of skills and expertise which will be needed in the future, including the services that can be expected from the new policy directions.

The case for change is outlined in more detail in attachment A.

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<sup>41</sup> Ballenden, N, & Duggan, M (2015). Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness. Australian and New Zealand College of Psychiatrists.

## 2. The proposed service model (mental health component)

### 2.1 Service model approach

The service model is grounded in evidence-based practice – reflecting practice outlined in collaborative care, primary care and mental health integration and chronic care models which have shown to improve mental health outcomes in the primary care environment and are consistently more cost effective, responsive and accessible.<sup>42</sup>

It specifically recognises the presence of mental health expertise within these models as part of the success of achieving good mental health outcomes, and also the importance of tailoring and adapting health interventions to meet the needs of people with a mental illness and complex support needs.

It builds on the existing Victorian community health service platform because it offers:

- Existing quality and support systems for the delivery of clinical care.
- Accessible, non-discriminatory, welcoming and locally based services – this means increased access and more opportunities for early intervention.
- A track record for working with people who are social disadvantaged and marginalised and working within a social model of health.
- Experience in delivering evidenced models of care – including the chronic disease model – which is also effective for people with a mental illness.

### 2.2 Key features

#### **Gateway for community-based mental health services and for people with a mental illness**

Victorian community health services already provide an accessible and local gateway for people requiring a range of health and social support services. Centralised intake, screening and assessment processes identify where people need to be referred and what services they might need.

This integrated model will provide navigation and intake for community mental health services – providing advice to consumers and their families about what services are available and how the system works, as well as providing advice and referral pathways from other services (including GPs, housing and other community services, NDIS) who are seeking additional or specialist mental health support for their clients.

#### **Inter / multidisciplinary team**

A (mostly) new mental health and wellbeing sub-team of counsellors, psychologists, mental health nurses, alcohol and other drug (AOD) workers, social workers and mental health workers join existing multidisciplinary allied health teams that exist in community health services.

The sub-team composition aims to provide mental health support across a spectrum of need and provide real choice and alternatives around mental health treatment options.

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<sup>42</sup> See Attachment B for a summary of the evidence base.

Each member will embrace inter-professional practice to ensure collaboration and service integration.

### **Care coordination**

Care coordinators oversee and support service access and coordination for people with chronic and complex support needs (eg: coordinate appointments for the same day, information sharing, checking goals being met), facilitate receipt and follow up of referrals from external providers and support shared care arrangements (including step up/secondary consultation when required) – this will include with the NDIS, general practitioners or clinical mental health services.

The care coordination role can and should also be undertaken by other team members. In this model, the mental health workers would take on this role for those people who have significant mental health needs. A key role will be the coordination and support for people who require stepped up or step down care

### **Integrated care and comprehensive assessment**

Physical and mental health would be linked from the beginning through comprehensive client focussed screening – ‘what are your needs and what do you want assistance with?’ – for both mental health and physical health needs.

Assessment remains an ongoing function throughout the time the client is linked with the service, enabling an ongoing review and setting of health goals.

### **Same day response<sup>43</sup>**

A key element of the success of the primary care and mental health integration model is the capacity for an immediate same day response (although there is evidence that if appointments are made within 24 hours, the retention rate remains very high).<sup>44</sup> At cohealth, we have seen that a consistent and comprehensive intake process in which people receive an initial response to their presenting issues is an important engagement and demand management tool. Linked to this is the aim for a no wrong door approach within the organisation.

As e-tools become more available (as promoted by both the Commonwealth and the State future mental health plans) referral to and use of these tools will become an important part of this initial response.

### **Step up mental health support**

While significant mental health expertise will exist within the team, additional support will be arranged through access to specialist GPs/consultant psychiatrists and/or arrangements with clinical mental health services.

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<sup>43</sup> The focus of the same day response is to respond to the immediate presenting need and engage with the person so that they come back for an appointment. This is different from a formal ‘brief intervention’, although brief interventions could form part of this process.

<sup>44</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1

The care coordinator role means that the model actively supports shared care arrangements and it would provide a referral pathway for clinical services and GPs seeking a more holistic response to their client's health needs.

### **Mental health program components**

The mental health and wellbeing sub-team would be expected to add the following service components to the current service offering:

- Psychological interventions such as CBT for people with more complex needs.
- Peer led interventions and support.
- Group programs such as optimal health, mindfulness, hearing voices.
- Dual diagnosis support – this would include assisting people with AOD issues which impact on their mental health but who are not eligible for AOD services.
- Capacity to provide secondary consultation and leadership internally and externally and manage links and shared care arrangements with clinical mental health services, external GPs and private psychiatrists.
- Service coordination – including support to access other health and disability services (eg: NDIS, housing, family support).
- Family and carer support.
- Counselling for low prevalence disorders and mental health support for the approximately 60% of people with chronic health conditions who have a mental health issue.
- Mental health focussed health management opportunities and health literacy activities (eg: smoking cessation, nutrition, impact of psychiatric medications, exercise).

## **3. Scope**

### **3.1 The Target Group**

- People with a psychosocial disability who are ineligible for NDIS on the basis of not having a permanent disability (or are yet to determine eligibility for the NDIS).
- People with a mental illness who require mental health and psychosocial support (other than medication support) related to managing their mental health and wellbeing or other health issues.
- People who are accessing the NDIS but need support to address their physical and/or mental health needs.
- People with chronic conditions or at risk of developing a chronic condition with psychosocial/ mental health issues.
- People with complex support needs and chaotic presentations

### **3.2 Geographic coverage/service locations**

The service should be locally based – available in community health service, or small PHN, areas aligning with relevant local government boundaries.

### 3.3 Service links and pathways

#### Clinical mental health services

The model relies on access to psychiatric (psychiatrist or registrar) support for secondary consultation and where necessary clinical support. This would be provided on a sessional basis, Medicare funded with staff from the clinical service. This ensures capacity for referral from inpatient units to the community health service team as well quick access to step up support.

#### General practitioners

The expanded community health team will be a referral option for GPs who identify that their clients with a mental illness require access to allied health services and care coordination.

#### Other community-based services – housing, homelessness, AOD, family, children's services etc.

As the key provider for specialist community mental health services, and with the intake and service navigation responsibilities, CMH will provide important referral pathways from and to a range of community-based services, including housing and homelessness services.

#### NDIS

The community health service will be a key referral point for people with a mental health issue accessing the NDIS with identified complex health needs, while the mental health team will be actively supporting people to access the NDIS where appropriate.

## 4. Staffing Model

### 4.1 Possible staffing profile for mental health component

- Peer workers
- Psychologists/ mental health nurse/ occupational therapist
- Social workers/ counsellors
- Mental health workers/ mental health care coordinators
- Specialist AOD workers
- Psychiatric registrar/ psychiatrist (sessional basis)

### 4.2 Mental Health Worker

The mental health worker is the new role within the model. Mental health workers would work on an outreach basis – linking with people in their own homes and communities - as well providing appointment-based support from the service site. Where appropriate assertive outreach and engagement could also occur.

The workforce would comprise a range of disciplines including peer support workers.

Key roles include:

- Participating as an expert mental health worker and care coordinator within the multidisciplinary team for people whose primary need is mental health related. This also includes supporting access to stepped up care and external supports.

- Actively coordinate, support and promote access to physical health services for people with a mental illness.
- Providing health and motivational coaching to assist people to achieve their physical and mental health goals.
- Establishing an empowering and respectful relationship with the client, to assist the client in managing and monitoring their mental health and health concerns.
- Assisting people with a mental illness and complex needs to address presenting issues, such as housing or drug and alcohol issues.
- Working collaboratively with the client and their family or other carers, including assisting and supporting family or other carers in their caring roles.
- Providing short to medium term psychosocial interventions for people who are not eligible for the NDIS.
- Responding in a crisis and/or intervening before a crisis. This may include housing, relationship or financial issues and support to maintain connections with community and family.
- Supporting the broader team in providing health literacy and health management programs tailored for people with a mental illness.
- Advocating and assisting people with a psychosocial disability to register for NDIS support.

## 5. Workforce

The modelling responds to the needs of people with a severe mental illness and a psychosocial disability.

This group, because of their disability, is expected to have a range of mental health and complex psychosocial support needs. However, the actual target group is broader than this subgroup as the model complements, not replicates, the NDIS and will also complement clinical services (depending on which components are accessed).

It assumes that 30% of clients will be accessing more than one service offering within the model (eg: psychologist support and mental health worker support).

The proposed start up staffing profile for a small PHN area is:

- 3 FTE – psychologist/ mental health nurse/ occupational therapist (1277 hours per FTE)
- 3 FTE – social worker/ counsellor (1277 hours per FTE)
- 2 FTE – AOD worker (1277 hours per FTE)
- 8 FTE – mental health worker including peer workers (1277 hours per FTE)

## 6. Limitations

The model is predicated on the existence of a multidisciplinary allied health team and community health services which have sufficient infrastructure to invest in patient management information systems, standardised and/or centralised intake and screening processes and a commitment to client centred care.

Strong links with clinical mental health services will significantly increase the capacity of the service to work with people with more complex needs. This partnership will need to be actively supported by government.

The cohealth community health service also provides GP and other Medicare funded services which will further enhance outcomes of the above model. For services without GPs, strong links with primary health care networks and/or local GP practices will be particularly necessary.

## Attachment A: The Case for Change

### Choice is important

The desire for increased choice has been well articulated in government policy, such as the Victorian 10-year Mental Health Plan. With the public mental health system the only option for clinical treatment for people with serious mental illness and/or who are unable to access private psychiatric care, there is little choice.

This model provides an alternative for clinical care, as well as a step down or complementary service within the service system.

### Placed based and local service delivery is preferred

cohealth consumers continue to confirm that local place-based services are preferred over hospital settings. There is a significant evidence base which suggests that community-based settings are more welcoming/less intimidating which increases the likelihood of seeking support.<sup>45</sup>

This means better early intervention opportunities for people who may be becoming unwell but do not yet meet the criteria for entry into clinical services.

### Integrated service delivery can deliver on better mental health and physical health outcomes for people with a mental illness

For too long Australia has failed to integrate mental health and physical health care people with a mental illness and there is a growing awareness that this must be addressed.<sup>46</sup>

Current responses to address the poor physical health of people with a mental illness predominately rely on specialist mental health services undertaking screening and referring to physical health providers. Limitations with this have included referrals not being made and a lack of skills, awareness and capacity of the health services to respond. The evidence base for achieving better health outcomes in this area points to the need to adapt physical health programs for people with a mental illness. Most have also been delivered in the specialist environment. We believe that a fully integrated approach in the mainstream community health environment – supported by mental health professionals - will deliver a more accessible service with at least equal health outcomes.

There is also a view that the separation of mental health from general health care is no longer appropriate and in fact is detrimental in terms financing and political support by continuing to promote the notion that mental disorders and mental health are somehow fundamentally different.<sup>47</sup> The Commonwealth has also questioned why models used in the general health care environment – such as chronic disease coordination – are not being used for people with a mental illness.<sup>48</sup>

<sup>45</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1

<sup>46</sup> Bailenden, N, & Duggan, M (2015). *Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness*. Australian and New Zealand College of Psychiatrists

<sup>47</sup> Drake, R, Green, A, Mueser, K, & Goldman, H. (2003). The history of community mental health treatment and rehabilitation for people with severe mental illness. *Community Mental Health Journal*, 427-40

<sup>48</sup> Commonwealth of Australia (2015). *Australian Government response to contributing lives, thriving communities - review of mental health programmes and services*. Commonwealth of Australia

### **People with chronic health needs usually require psycho-social support**

While community health has the capacity to determine allocation of allied health funding between disciplines demand continues to outstrip supply. Enhanced capacity for psychosocial support, particularly for those with chronic disease and/or with multiple risk factors should improve outcomes for the 5% of people in the highest risk category (people with multiple comorbidities and psychosocial needs) and the 20% who without intervention due to multiple risk factors will enter into the highest risk category (called emerging risk)<sup>49</sup>.

At cohealth our service use profile broadly matches these groups – the emerging risk group are identified as people accessing two allied health service types (18% of all allied health service clients) and the high risk group indicated by clients accessing more than three allied health service types (5%) of which 32% included a counselling service (compares to 8% for all clients). However, at less than 1% of the total population it is expected that demand is much higher than usage rates.

### **The service system has changed and is changing**

There is a growing evidence base of the effectiveness of peer support models and consumer delivered services<sup>50</sup> and a strong evidence base for the effectiveness of addressing mental health needs in primary care, rather than specialised, mental health service environments.<sup>51</sup> The track record for improving physical health outcomes and life expectancy for people with a mental illness has been appalling and there is a growing awareness that this must be addressed,<sup>52</sup> while the provision of safe and secure housing is positively identified for improved mental health outcomes but still remains elusive.

### **State and Federal Government directions**

The Draft Report of the Federal Productivity Commission Inquiry into Mental Health and the Interim Report of the Royal Commission into Victoria's Mental Health System both identify serious system failures in mental health.

These reflect earlier findings from previous reviews<sup>53</sup>. The Australian Government in its *Response to Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services*<sup>54</sup> acknowledged many of the concerns raised in the review – including a lack of service coordination and integration and appropriate responses to people with different needs. It identified that there are opportunities for supporting the primary care environment to develop more comprehensive and responsive services to people with a mental illness across the spectrum of need, as well as building on existing chronic disease coordination programs to produce improved results for people with a mental illness. It also noted concerns about the sizeable group of people who are not supported by the state system or

<sup>49</sup> From the American Health Care Advisory Board

<sup>50</sup> Bond, G, & Kilculco, C (2008). Evidence Based Practice (check). *Journal of Rehabilitation*, 33-44

<sup>51</sup> See Attachment B

<sup>52</sup> Bailenden, N, & Duggan, M. (2015). *Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness*. Australian and New Zealand College of Psychiatrists.

<sup>53</sup> Such as the National Mental Health Commission, 2014: *The National Review of Mental Health Programmes and Services*. Sydney: NMHC.

<sup>54</sup> <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response>

the NDIS who have complex needs and a significant need for clinical care coordination to avert escalation of symptoms.

In Victoria, the State Government *10-Year Mental Health Plan* outlines the framework for better services for better outcomes: co-produce services; provide services that fit together as a whole; understand, respect and respond to diversity; and build and support the best possible workforce. It says that 'integrated service delivery will become the standard way that we operate'. It also identifies an early focus on ensuring limited disruption in transition for Victorians to the NDIS. The alignment of the CMH model with the *Victorian 10-year Mental Health Plan* is expanded on in attachment C.

**Not everyone with a disability is eligible or will receive an NDIS package (or it may take time to determine eligibility)**

The NDIS is not suitable for all people with a mental illness and psychosocial disability and will only respond to the small proportion of the population with a permanent, or likely to be permanent, disability.

For many people their disability is not permanent, and they do not need support on an ongoing basis. Neami have reported that of its 1500 clients across Australia only 6 – 13% of its client group remain engaged with their service for over five years – the majority received the support they needed and then moved on.<sup>55</sup> For many others their level of disability fluctuates<sup>56</sup>, making it unclear what support is required and/or whether the disability is permanent.

The Commonwealth identifies concern for people with a serious mental illness who are not supported by state mental health service systems or the NDIS but who have complex needs and need clinical care coordination to avert escalation of symptoms.<sup>57</sup>

As the Draft Report highlights there were 282,000 Australians requiring psychosocial disability support services in 2016, but only 64,000 – or 23% - will be eligible for support through the NDIS.<sup>58</sup> We expect that these disability support needs will be across the spectrum of high to low need – but are most likely to require short to medium term and intermittent responses.

**The NDIS provides a limited range of supports - people with a mental illness still need community mental health services**

While the NDIS will play an important role in supporting eligible people on their psychosocial rehabilitation journey, the NDIS does not and did not set out to provide psychosocial rehabilitation. This is a change for both NDIS participants and people who are ineligible. While there is some overlap and consistency with regard to the principles and practice of the NDIS and psychosocial rehabilitation – for example, a commitment to self-determination, attention to consumer preference, skills training and the need for

<sup>55</sup> Papakotsias, A., & Tobias, G. (2015). Differentiating holistic mental health care from disability care. *New Paradigm - Australian Journal for Psychosocial Rehabilitation*, 32-35.

<sup>56</sup> Deloitte (2013) PDRSS demand modelling report. This report showed that most people with a mental illness experience fluctuating levels of disability – for example the demand study showed that 12% of people with a mild disability had a historical rate of high to moderate disability, and 19% with high levels of disability had a historical rate of mild disability and 15% with a historical rate of no disability.

<sup>57</sup> Commonwealth of Australia. (2015). *Australian Government response to contributing lives, thriving communities - review of mental health programmes and services*. Commonwealth of Australia.

<sup>58</sup> Productivity Commission 2019, *Mental Health*, Draft Report, Canberra p430

environment modifications – there are also significant differences. Key differences include the workforce, the type of support available and how the support is provided. For example, the NDIS does not:

- Support the employment of a workforce which has an in-depth understanding of how illness and the experience of mental health impacts on people's lives and who can and will apply this knowledge to the intervention.<sup>59</sup> For example, learning to use transport may require teaching about using a myki or how to hail a bus, however, if that person has agoraphobia the travel training needs to include managing anxiety and fears.
- Provide direct support for family members in acknowledgement that the family can influence the recovery process.<sup>60</sup>
- Provide continuity – moving from high to low intensity of supports<sup>61</sup> including in the context of a service delivery episode. People's need for support can change quickly and/or the way it needs to be provided may change depending on the person's mental state on any given day.
- Provide early intervention, including being able respond in a crisis or to an impending crisis.<sup>62</sup>
- Emphasise strengths.<sup>63</sup>

Naughtin and Grigg<sup>64</sup> further explain that in psychosocial rehabilitation engagement, assessment and interaction is iterative – that is the staff member providing the support continually engages, assesses and changes the interaction in order to support, encourage and assist another person to be motivated to make changes in their life.

The NDIS also will not provide health service care coordination where the need for coordination is mostly around health needs (eg: AOD support, diabetes, dental care).

### **Community mental health care is cost effective.**

The community health environment is a flexible and responsive service delivery platform thus reducing the costs of similar services through the hospital. Combined with a capacity for early intervention and multidisciplinary teams it is well placed to reduce demand for both clinical mental health and other acute health services.

The evidence base for integrated mental health primary care platforms consistently show that it provides a more accessible, cost effective and responsive service than specialist or hospital delivered services<sup>65</sup>.

<sup>59</sup> Naughtin, G., & Grigg, M. (2015). Beyond NDIS - Community Managed Mental Health Services. *New Paradigm - the Australian Journal for Psychosocial Rehabilitation*, 17-19.

<sup>60</sup> Corrigan et al, 2008, cited in Naughtin, G., & Grigg, M. (2015). Beyond NDIS - Community Managed Mental Health Services. *New Paradigm - the Australian Journal for Psychosocial Rehabilitation*, 17-19.

<sup>61</sup> Corrigan et al, 2008, cited in Naughtin, G., & Grigg, M. (2015). Beyond NDIS - Community Managed Mental Health Services. *New Paradigm - the Australian Journal for Psychosocial Rehabilitation*, 17-19.

<sup>62</sup> Cnaan, R. (1988). Psychosocial Rehabilitation: toward a definition. *Psychosocial Rehabilitation Journal*.

<sup>63</sup> Cnaan, R. (1988). Psychosocial Rehabilitation: toward a definition. *Psychosocial Rehabilitation Journal*.

<sup>64</sup> Naughtin, G., & Grigg, M. (2015). Beyond NDIS - Community Managed Mental Health Services. *New Paradigm - the Australian Journal for Psychosocial Rehabilitation*, 17-19.

<sup>65</sup> See Attachment B – evidence base: a brief summary of literature

When this model was developed in 2015 we calculated that for every five day inpatient stay averted there is a cost saving of \$2,288 or for every 10 hours of clinical mental health support, a saving of \$2,898.

Star Health<sup>66</sup> reported on a community mental health clinic provided in partnership with Alfred Health but fully funded through Medicare and linked with, and supported by, its multidisciplinary and community mental health teams. It reported significant health and cost effectiveness outcomes, including:

- 100% of clients successfully maintaining a relationship with a prescribing GP.
- 76% accessing at least one Star Health primary health care service other than mental health (and 42% were accessing three or more).
- Demand for bed-based clinical services was significantly reduced in the very first year of the initiative, with data showing clients using 60% fewer bed-days. Significantly, bed day usage was increasingly being diverted from acute to recovery-focused sub-acute care, indicating clients were not as unwell even when they required bed days. Acute bed days usage dropped from 227 days to 49 days, while use of the less intensive sub-acute bed days (and lower system cost) only increased from 19 to 51 days.

Such a model needs to be underpinned and supported by a service coordination function in which there are pathways for clients in and out of the service, and which supports clients attending appointments, an important factor for financial viability of the program.

## Conclusion

The Draft Report from the Federal Productivity Commission Inquiry into Mental Health, the Interim Report of the Royal Commission into Victoria's Mental Health System and the completed roll-out of the NDIS are a catalyst to rethink how mental health services could and should be structured.

There is a strong opportunity to create a new model that finally addresses people's physical and mental health with specialised psychosocial support for people with a mental illness.

It maximises access to Medicare funded and NDIS services to ensure the best outcomes for everyone.

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<sup>66</sup> Murnane, A. (2015). Innovation and Rehabilitation in Victorian Mental Health. *New Paradigm - Australian Journal for Psychosocial Rehabilitation*, 28-31.

## Attachment B: The evidence base for primary health and mental health care integration – brief summary of literature

There is a strong evidence base to support the proposed model. cohealth has already been investing and trialling multidisciplinary team environments working in a chronic care model and is already exploring how to better integrate mental health service delivery.

A literature review identified three main (but very closely linked) models which have efficacy in improving mental health outcomes in the primary care environment and are consistently seen as more cost effective, responsive and accessible.

### Collaborative care

Care that is delivered by providers from different specialities, disciplines or sectors working together to offer complementary services and mutual support. There is strong evidence for reducing psychopathology for common mental illnesses and mixed results for patients with psychosis, who use alcohol or other drugs or who use a high volume of mental health care.<sup>67</sup> Collaborative care delivers on improved access, is more efficient regarding referral delay, duration of treatment, number of appointments and related treatment costs.<sup>68</sup> There is also increased capacity of primary care to manage mental health and addiction.<sup>69</sup> Key components are effective communication, consultation, coordination, collocation and integration.

### Primary care and mental health integration

The key feature of primary care and mental health integration is a 'behavioural health consultant (BHC)' who is embedded as a full-time member of the primary care team. They are available for an immediate referral from the GP and undertake initial screening, identify immediate short-term interventions, complete relevant paper work, prepare a comprehensive treatment plan and provide or organise access other therapies or interventions. These consultants can often also provide AOD interventions.

The behavioural health consultation team consists of psychologists, social workers, and trainees (e.g. practicum students, interns, and post-doctoral fellows). BHCs are also important for people presenting with medical/chronic/complex problems who may also have mental health issues and there is growing evidence that the BHC model affords opportunities for early identification and that behavioural and/or medical intervention can prevent some acute problems from becoming chronic health care problems.

Common BHC interventions are acceptance-based strategies, problem solving, mindfulness training, cognitive thought reframing worksheets, behavioural activity, stimulus control/sleep hygiene, motivational interviewing and psychoeducation<sup>70</sup> counselling and self-management plans.

<sup>67</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1.

<sup>68</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1.

<sup>69</sup> Kates, N, Mazowita, G, Lemire, F & Jayabarathan, A (2011) The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future *Canadian Journal of Psychiatry* 56(5)

<sup>70</sup> Vogel, M., Malcore, S., Illes, R., & Kirkpatrick, H. (2014). Integrated Primary Care: Why you should care and how to get started. *Journal of Mental Health Counselling*, 130.

Benefits of primary care/mental health integration include: more cost effective when compared to specialised care<sup>71</sup>; provides access to treatment earlier<sup>72</sup> – there is some evidence to suggest that the immediate warm referral to the BHC increases access; increased use and access to mental health services<sup>73</sup>; some emerging evidence that it provides better access to for people from CALD/ marginalised backgrounds due to delivery in non-stigmatising environment<sup>74</sup>; delivers equal to better outcomes when compared to specialised care<sup>75</sup>; and where consulting psychiatry is available primary care clinicians are supported to meet needs of people with a mental illness.<sup>76</sup>

### **The Chronic Care Model (CCM)**

This model has been shown to improve medical and psychiatric outcomes for people with mental illnesses in primary care settings with little or no net health care cost,<sup>77</sup>.

Its key features are:

- Co-located care manager (i.e. nurse or clinical social worker) to provide systematic care management.
- Care manager provides counselling/ education to patients on self-management, monitors outcomes and consults with mental health specialist (i.e. psychiatrist) for more complex cases.
- Mental health specialist is either co-located or located off site with contractual arrangement to provide consultation.
- While each model differs slightly, some key features which seem particularly important to achieving outcomes include:
  - Comprehensive screening for mental health and chronic health conditions.
  - Immediate or very short-term access to services (eg: warm referrals, same day appointments).
  - Integrated multidisciplinary teams (rather than co-located).
  - Care planning.
  - Care planners providing services and interventions (not just coordinating).
  - Availability of self-management programs.

<sup>71</sup> Vogel, M., Malcore, S., Illes, R., & Kirkpatrick, H. (2014). Integrated Primary Care: Why you should care and how to get started. *Journal of Mental Health Counselling*, 130; Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1.

<sup>72</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1.

<sup>73</sup> Johnson-Larence, V., Zivin, K., Szymanski, B., Pfeiffer, P., & Carthy, J. M. (2012). VA Primary Care - Mental Health Integration: Patient Characteristics and Receipt of Mental Health Services. *Psychiatric Services*, 1137-1411.

<sup>74</sup> Zeidler-Schreiter, E., Pandhi, N., Fondow, M., Thomas, C., Vonk, J., Reardon, C., & Serrano, N. (2013). Consulting psychiatry within an integrated primary care model. *Journal of Health Care for the Poor and Underserved*, 1522-1530; Vogel, M., Malcore, S., Illes, R., & Kirkpatrick, H. (2014). Integrated Primary Care: Why you should care and how to get started. *Journal of Mental Health Counselling*, 130.

<sup>75</sup> Orden. (2009). Collaborative mental health care vs care as usual in a primary care setting. *Psychiatric Services*, vol 6:1.

<sup>76</sup> Zeidler-Schreiter, E., Pandhi, N., Fondow, M., Thomas, C., Vonk, J., Reardon, C., & Serrano, N. (2013). Consulting psychiatry within an integrated primary care model. *Journal of Health Care for the Poor and Underserved*, 1522-1530

<sup>77</sup> O'Donnell, Williams, & Kilbourne (2013) Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care *J Gen Intern Med* 28 (12): 1667-1672

In addition, a number of the models include access to a consultant psychiatrist for review and support, including for people with serious mental illness and/or when outcomes are not being achieved as expected.

### **Achieving physical health outcomes**

While the issue of poor physical health and comorbidities for people with a mental illness is well established, there is a lack of existing practice to address the issue.<sup>78</sup> However, there are a number of specific interventions identified in the literature which suggest that health literacy and health behaviour interventions need to be adapted to the needs of people with a mental illness and be delivered in an integrated and supported way, for example registered nurses taking responsibility for educating and coaching patients<sup>79</sup>, or a program for young people experiencing a first psychosis delivered by a multidisciplinary teams involving nurses, exercise physiologists and others.<sup>80</sup>

Interestingly a 2010 pilot by EACH and Inner South Community Health Service (now Star Health) to improve access to primary care services for people with a mental illness identified a number of issues including communication between the mental health services providing screening and the primary health practitioners, a lack of skills and confidence in primary care providers to address physical health needs and availability and suitability of 'health supports and programs' for people with a mental illness.<sup>81</sup> The proposed model overcomes these barriers by locating screening and service delivery within the one team and provides sufficient mental health expertise to support the range of health interventions available.

### **The consumer perspective**

There is limited consumer commentary in the peer reviewed literature. Henderson & Fuller<sup>82</sup> identify that policy has focussed on lifestyle and access to Medicare treatment as causes of poor physical health and that policy solutions target a greater reliance upon primary and collaborative care models, the monitoring of physical health and lifestyle factors by mental health teams and the promotion healthy lifestyles among people with mental illnesses.

They raise concerns that the role of socio-economic inequity is not factored in and are critical that the structural and attitudinal barriers that currently prevent effective integration between primary care and specialist mental health services have not been addressed. They are concerned about a dependence on primary health care services – arguing that they are less affordable, accessible and able to meet the needs of people with low prevalence disorders.

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<sup>78</sup> Ballenden, N., & Duggan, M. (2015). *Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness*. Australian and New Zealand College of Psychiatrists.

<sup>79</sup> Druss, B. G., Esenwien, S. A., Compton, M., Zhao, L., & Leslie, D. (2011). Budget impact and sustainability of medical care management for persons with serious mental illness. *American Journal of Psychiatry*, 1171-1178.

<sup>80</sup> Curtis et al., 2015 in Ballenden, N., & Duggan, M. (2015). *Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness*. Australian and New Zealand College of Psychiatrists.

<sup>81</sup> Davidson, M., & O'Boyle, S. (2010). *Improving access to primary health care services for people with serious mental illness demonstration project*.

<sup>82</sup> Henderson, J., & Fuller, J. (2011). 'Problematising' Australian policy representations in responses to the physical health of people with mental health disorders. *Australian Journal of Social Issues*, 188-203.

Consultation within cohealth regarding the Victorian 10-year Mental Health Plan identified that consumers valued place-based service delivery which was non-stigmatising, opportunities for social interaction and service responses which were immediate (ie not appointment based). Consumers were also concerned about relying on GPs to provide mental health care.

Van Hasselt et al<sup>83</sup> explored patients' and carers' views of how care for physical health could be improved. Three major themes were identified:

- The reduced ability of patients with serious mental illness to survey their own physical health interests requires health care that is tailored to these needs.
- The lack of collaboration amongst mental health-care professionals and GPs hinders optimal care.
- Chronic disease prevention programs and healthy lifestyle interventions need to be adapted to the special needs of this group - one size does not fit all (this latter point was also one of the conclusions of the EACH/ ISCH pilot to improve physical health outcomes for people with a mental illness).

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<sup>83</sup> Van Hasselt et al (2013) in Ballenden, N., & Duggan, M. (2015). *Keeping Body and Mind Together - Improving the physical health and life expectancy of people with serious mental illness*. Australian and New Zealand College of Psychiatrists.

**Attachment C: Example of alignment with government policy – the Victorian 10-year Mental Health Plan**

<b>Victoria's 10-year mental health plan</b>	<b>Community Mental Health – a vision for integrated primary health and community mental health</b>
Coproductio n of services	<p>cohealth has embraced consumer coproduction across its service. Many aspects of this model have arisen directly from consumer feedback about what services should look like and what works.</p> <p>However, coproduction is not a one off or static process and needs to be built into the ongoing development and delivery of services – including the involvement of people directly in receipt of services.</p> <p>This model builds in a consumer workforce while also providing for choice and control throughout the service delivery episode.</p>
Provide services that fit together as a whole	<p>This pilot integrates mental health services into the community mental multidisciplinary team. It adopts the community health funding model and the expectation is for shared assessment, planning and service delivery.</p> <p>Importantly, it also acknowledges the importance of service coordination within the service and externally. The designated service coordinator roles will support this.</p> <p>As a new gateway for community mental health – consumers, carers and service providers will have clarity about where to find information about the services they need.</p>
Understand, respect and respond to diversity	<p>Community health works from a social model of health and targets people who are otherwise marginalized from many mainstream services.</p> <p>We offer a safe, welcoming and inclusive environment free from discrimination. The connections with local community and accessible street frontages also improve engagement with people who may otherwise not access services.</p>
Build and support the best possible workforce	<p>The skilled and experienced community mental health workforce has undergone significant change as a result of the rollout of the NDIS, with many roles ceasing to exist.</p> <p>In addition to the loss of this specialised support for people with severe mental illness, there are implications for continuing programs, such as PARCs, which have relied on this workforce, and the organisations that support them.</p> <p>This proposal ensures that this workforce is retained and rebuilt for the future, in environments that support the development of the knowledge and capability of the sector.</p>