

## Response to Australian Government Productivity Commission Draft Mental Health Report



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## Introduction

Relationships Australia Victoria (RAV) welcomes the opportunity to provide a response to the Productivity Commission's Mental Health Draft Paper.

RAV is a state-wide, not-for-profit, community organisation that delivers a wide range of family, relationship and mental health support services delivered from 16 locations across metropolitan Melbourne and regional Victoria. Our universal services include couple counselling, family therapy, family dispute resolution (mediation), relationship education, family violence prevention, support and recovery services, including Men's Behaviour Change Programs.

Our mental health programs include promotion, early intervention, and tertiary services:

- We are the lead agency of two headspace centres and consortium partners in two others.
- Our Reclaim program has provided specialist complex trauma and case management support for people affected by the Royal Commission into institutional responses to child sex abuse.
- We provide trauma informed counselling and support to people who are affected by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
- Our Early Matters program seeks to promote and strengthen healthy relationships to prevent families from entering a stress pathway. This multi-component program includes group programs and a Home Visiting/Outreach Service to work with families at three critical high-risk transition points: After the birth of a new baby – post-natal/post-partum relationships; School readiness for kindergarten children with their parents; and Children in middle to late primary school and transitioning to high school.
- *i-Connect* is RAV's Family Mental Health Support Service delivering support to children and young people in East Gippsland at risk of or affected by mental illness
- Our Compass Forced Adoption Support Services uses a case management model to support people with complex needs who have been affected by forced adoption policies and practices, including mothers, people who were adopted, and family members.
- In partnership with Hawthorn headspace we have developed an innovative evidence-based trauma recovery program '*Right Now*'. This six-week program seeks to address embodied traumatic stress through engagement with body-based and other non-verbally mediated strategies to assist women affected by interpersonal violence. The program compliments our specialist Family Violence Counselling program
- Our successful *I like, like you* program delivered in primary and secondary schools is an early intervention relationships program that promotes the connection between healthy intimate relationships and emotional health and wellbeing.
- RAV has delivered ATAPS programs as part of Bush Fire recovery initiatives.

It is in the context of our experience in delivering this wide range of community-based mental health programs and services that we make our contribution.

## Executive Summary

As a not for profit community organisation delivering a range of mental health services and programs RAV enjoys a number of effective collaborative working relationships with primary health care, high intensity care and complex care providers. However, consistent with the Commission's Draft Report, we believe the current

mental health system is fragmented and not adequately resourced and structured to meet the needs of the Australian population. We support the proposition that Australia's mental health system requires fundamental reform to give all Australians access to mental healthcare at a level of care that most suits their treatment needs in a timely and culturally appropriate way.

We believe that a greater integration of traditional mental health services with community-based organisations offering universal as well specialist mental health programs can greatly enhance mental health outcomes, extend consumer choice and contribute to reducing stigma and discrimination. We support the expansion of digital and online treatment options proposed in the report<sup>1</sup>; and endorse the majority of other recommendations in the report. However, we have confined our detailed responses to those recommendations most relevant to our expertise and knowledge.

RAV strongly supports the proposal to rebuild the mental health system within the framework of a new whole-of-government *National Mental Health Strategy*. We believe the Strategy will require the integration of six key elements, which reflect the main themes of our submission:

1. Improved assessment and referral practices should be developed in conjunction with strategies to encourage help-seeking behaviour. Services need to be developed in such a way as to ensure that they are made more accessible to those less likely to seek help. For example, men are far less likely to seek medical support for a mental health problem than women. In our view, the requirement that consumers need a referral from a GP into the Better Access scheme is an unnecessary restriction. Extending referral authority to community based mental health nurses should be considered as part of the reform<sup>2</sup>.
2. Australia's mental health strategy should include a public mental health plan that combines education, promotion, and prevention approaches: A public mental health approach will be concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems. Universal interventions that promote mental wellbeing across whole populations should be integrated with progressively targeted interventions to address specific needs among more vulnerable and at-risk groups. A public health plan will aim to build literacy from an early age in mental and emotional wellbeing maintenance, resiliency and stress management practices throughout life.
3. *A life course approach to mental health that emphasizes prevention and early intervention at every life stage:* We strongly endorse proposals to improve prevention and early intervention strategies in schools. However, we argue that a new mental health strategy for Australia should adopt a life course approach that emphasizes prevention and early intervention at every life stage with a particular focus on key life transitions. In our view, consideration of the mental

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<sup>1</sup>RAV has recently developed online counselling capacity as well as telephone counselling to complement our face to face counselling delivery

<sup>2</sup> In line with the proposed expanded role of mental health nurses recommended in the Commission's draft report.

health needs and challenges associated with an ageing population is a significant omission in the current report.

4. *The integration of relationship-based intervention in mental health treatment plans:* Often the foundations of mental health are laid down in infancy in the context of family relationships and social relationships are protective of mental health for all people. Distressed relationships have a significant impact on mental and physical health. Mental illness often impairs peoples capacity to form and maintain relationships. Targeted services strengthening and repairing relationships at all life phases are integral to an effective mental health strategy. Family focused interventions should be available as part of all mental health treatment plans
5. *A new mental health strategy must adopt a trauma informed approach to be effective:* A major gap in mental health services is the role trauma plays in mental illness. There is significant increased risk for any DSM-V psychiatric disorders following exposure to childhood abuse. In routine practice, a trauma assessment should be undertaken to ensure that appropriate treatment options are provided; and where indicated, addressing childhood trauma should be a focus of early intervention strategies and approaches.
6. *An effective interdisciplinary workforce trained in recovery orientated principles:* RAV believes that Interprofessional Collaborative Practice (ICP) within healthcare services is necessary to respond to the multi-faceted needs of consumers.<sup>3</sup> The ethos of collaborative practice and recovery orientated practice must be expanded upon and demonstrated more readily across mental healthcare services and professions to form part of a collective professional identity

## Re-orientating health services to consumers

### DRAFT RECOMMENDATION 5.9: ENSURING ACCESS TO THE RIGHT LEVEL OF CARE

*The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare at a level of care that most suit their treatment needs (in line with the stepped care model) that is timely and culturally appropriate*

RAV endorses the stepped care model and supports proposed practical measures in the draft report to promote and monitor best practice in initial assessment and referral. (*Recommendation 5.2*). Recognising that different proportions of the population will experience different levels of need with respect to Mental Health services is critical in building effective and efficient mental health support.

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<sup>3</sup> RAV's response to this section is informed a recent literature review of effective collaboration models we have conducted in partnership with Swinburne University as the first stage to developing more effective workforce and corporate training and strengthening collaboration theory and practice content in tertiary education. A co-authored paper has been submitted to the Journal of Interprofessional Care: *Interprofessional Education and Interprofessional Collaborative Practice: A review of current initiatives in primary healthcare with a focus on mental health in Australia.*

Whilst recognising that, we would also emphasise the importance to the design of the mental health system going forward of a strength based and recovery-orientated framework in line with the national framework for *Recovery Orientated Mental Health Services*. Best practice assessment and referral is needed to help people find the right combination of services, treatments and supports *at every phase* of their recovery. As consumers move through phases of recovery it is essential that they are supported in the most effective ways, allowing smooth 'step-down' transitions and access to evidence-based health maintenance therapies, such as mindfulness. Particular attention needs to be paid to developing a more sophisticated and effective intersection of mental health providers and non-health supports in the stepped care model.

Further, we argue a mental health system reconfigured to give all Australians access to mental healthcare at a level of care that most suit their treatment needs must:

- Be trauma orientated
- Include Relationship support services
- Focus on encouraging earlier help-seeking

We expand on this below.

### Initial Assessment for Trauma Is Essential

RAV strongly argues that best practice initial assessment and referral must include comprehensive trauma assessment and treatment options.

A major gap in mental health support services not specifically identified in the Commission's draft report is the role trauma plays in mental illness. As the Blueknot Foundation have pointed out:

*Our mental health system is based on symptoms and diagnosis. This is based on the question: what is wrong with a person? This system often doesn't consider: what happened to the person to have affected them so profoundly? How did they cope? How are they coping now? This often ignores the context of their lives and their trauma.*

*Screening and assessment for trauma, abuse and violence is not standard. This is despite the numbers of people who have experience trauma attending different services. Two of three people attending emergency, inpatient or outpatient mental health services have complex trauma from childhood physical or sexual abuse (Read et al., 2005).*

*Trauma can cause a lot of mental distress over time. It also affects a person's ability to seek support, feel safe, trust and stay connected to services. The way services respond is important for recovery.*

The WHO (World Health Organization) estimates that a quarter of all adults report having been physically abused as a child, with childhood sexual abuse reported by one in five women and one in 13 men.<sup>4</sup> In individuals suffering from severe mental disorders, childhood trauma is reported at a much higher rate. For example, a study from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) has investigated the risk for any DSM-IV psychiatric disorders when exposed to childhood physical abuse. Such

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<sup>4</sup> WHO Library Cataloguing-in-Publication Data. World Health Organization and International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. In (Anonymous). 2006.

an exposure is associated with increased risks for a range of mental health disorders, including substance disorders, psychotic disorders, mood and anxiety disorders, and any suicide attempt.<sup>5</sup>

A routine assessment of childhood trauma in both the early phases and established cases mental illness should be undertaken due to the heightened risk of developing a more severe illness over time. It has previously been reported that abuse is often inadequately assessed in psychiatric clinics.<sup>6</sup> The assessment of childhood trauma is particularly required for subgroups of patients with Bipolar Disorder early onset, comorbidity with suicide attempts or substance misuse, high level of mood recurrences or greater mood instability.<sup>7</sup> Childhood trauma has been associated with a poorer response in resistant-depression, obsessive-compulsive disorder and schizophrenia.<sup>8</sup> In routine practice, an assessment should be undertaken to ensure that appropriate treatment options are provided; and where indicated, addressing childhood trauma should be a focus of early intervention strategies and approaches to potentially prevent these individuals from developing an unalterable chronic illness over time for many mental illness presentations. Because a history of childhood trauma is also associated with reduced functioning in childhood, reaching these individuals before illness onset could potentially reduce the severity and (hypothetically) the development of the illness.<sup>9</sup>

Examples of treatment targets (working directly on the dissociative experiences in response to trauma) could be psychological techniques, coping strategies, body awareness/ mindfulness techniques and stress management. Existing data supports several psychological interventions in effectively preventing or treating the negative consequences of childhood trauma in general (eye moment desensitization, known as EMDR, and reprocessing and trauma focused Cognitive behavioural therapy for sexually abused children),<sup>10</sup>

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<sup>5</sup> any substance use disorders (OR = 1.24 [1.07, 1.44]), psychotic disorders (OR = 1.27 [1.00, 1.61]), any mood disorders (OR = 1.41 [1.25, 1.60]), any anxiety disorders (OR = 1.56 [1.38, 1.77]), and any suicide attempts (OR = 1.57 [1.26, 1.96]) (Sugaya et al. . Child physical abuse and adult mental health: a national study. *J Trauma Stress*. 2012;25:384–92.)

<sup>6</sup> Read J, Fraser A. Staff response to abuse histories of psychiatric inpatients. *Aust NZ J Psychiatry*. 1998;32:206–13.

<sup>7</sup> Cited in Aas, M., Henry, C., Andreassen, O.A. *et al*. The role of childhood trauma in bipolar disorders. *Int J Bipolar Disord* 4, 2 (2016). <https://doi.org/10.1186/s40345-015-0042-0>

<sup>8</sup> Douglas KM, Porter RJ. The effect of childhood trauma on pharmacological treatment response in depressed inpatients. *Psychiatry Res*. 2012;200:1058–61; Shamseddeen W, Asarnow JR, Clarke G, Vitiello B, Wagner KD, Birmaher B, Keller MB, Emslie G, Iyengar S, Ryan ND, McCracken JT, Porta G, Mayes T, Brent DA. Impact of physical and sexual abuse on treatment response in the Treatment of Resistant Depression in Adolescent Study (TORDIA). *J Am Acad Child Adolesc Psychiatry*. 2011;50:293–301; Hassan AN, de Luca V. The effect of lifetime adversities on resistance to antipsychotic treatment in schizophrenia patients. *Schizophr Res*. 2015;161:496–500; Semiz UB, Inanc L, Bezgin CH. Are trauma and dissociation related to treatment resistance in patients with obsessive-compulsive disorder? *Soc Psychiatry Psychiatr Epidemiol*. 2014;49:1287–96.

<sup>9</sup> Aas, M., Henry, C., Andreassen, O.A. *et al*. The role of childhood trauma in bipolar disorders. *Int J Bipolar Disord* 4, 2 (2016). <https://doi.org/10.1186/s40345-015-0042-0>

<sup>10</sup> Landin-Romero et al. and Mueser et al. assessed a sample of 108 patients with PTSD and either major mood disorder (85 %), schizoaffective disorder or schizophrenia (15 %), of whom 25 % also had a borderline personality disorder using CBT. CBT patients improved significantly more than patients in the treatment as usual group at a blinded post-treatment and the 3- and 6-month follow-up. Landin-Romero R, Novo P, Vicens V, McKenna PJ, Santed A, Pomarol-Clotet E, Salgado-Pineda P, Shapiro F, Amann BL. EMDR therapy modulates the default mode network in a subsyndromal, traumatized bipolar patient. *Neuropsychobiology*. 2013;67:181–4;

Due to findings of childhood trauma being associated with affective dysregulation in Bipolar Disorder and impulsivity as well as rapid cycling, psychosocial therapies should target not only traumatic experiences per se, but also cognitive defects or emotional dysregulation linked to traumatic experiences.<sup>11</sup> There is increasing evidence of the effectiveness of somatic integrative body-focused therapy for treating people with posttraumatic stress disorder (PTSD)<sup>12</sup>.

Systemic treatment approaches including couple, family, and group modalities also have an important role to play once severe dysregulation has been addressed.<sup>13</sup>

Therapies that target emotional regulation or cognitive functioning to help counterbalance the negative effects of trauma augmented by systemic therapies can be provided at relatively low cost often in group therapy modalities. As an organisation with extensive experience managing trauma programs, we would argue that a mental health system reconfigured to give all Australians access to mental healthcare at a level of care that most suits their treatment needs must include an expansion of trauma orientated programs available in both hospital and community settings. Complex PTSD linked with childhood trauma requires specialist understanding of the neuroscience of complex trauma and evidence based recognised and emerging therapies should be included as approved modalities in the MBS Better Access program.<sup>14</sup> “Core features of complex trauma therapy include engaging with right-brain processes, attending to the role of implicit memory and engaging with physical as well as cognitive and emotional processes – ‘we must attend to all three levels: cognitive processing... emotional processing...and sensorimotor processing (physical and sensory responses, sensations and movement’. While there are different ways of attending to these dimensions, current research confirms the need to address all three therapeutically”<sup>15</sup>

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Mueser KT, Rosenberg SD, Xie H, Jankowski MK, Bolton EE, Lu W, Hamblen JL, Rosenberg HJ, McHugo GJ, Wolfe R. A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol*. 2008;76:259–71.

<sup>11</sup> Aas, M., Henry, C., Andreassen, O.A. *et al*. The role of childhood trauma in bipolar disorders. *Int J Bipolar Disord* **4**, 2 (2016). <https://doi.org/10.1186/s40345-015-0042-0>

<sup>12</sup> E.g. [Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study](#)

Danny Brom, Yaffa Stokar, Cathy Lawi, Vered Nuriel-Porat, Yuval Ziv, Karen Lerner, Gina Ross *J Trauma Stress*. 2017 Jun; 30(3): 304–312. Published online 2017 Jun 6. doi: 10.1002/jts.22189 PMID: PMC5518443;

<sup>13</sup> Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide by Christine A. Courtois & Julian D. Ford New York: The Guilford Press, 2009; Stratton, P (2016). The Evidence Base of Family Therapy and Systemic Practice. Association for Family Therapy, UK.

<sup>14</sup> See Blue Knot Foundation 2019 Practice Guidelines for Clinical Treatment of Complex Trauma: Authors Kezelman C.A & Stavropoulos P.A. for a comprehensive review of evidence based practice in the treatment of Complex PTSD.

<sup>15</sup> Ibid p. 108

### **Non-health supports must include relationship support services:**

Despite the importance of relationships on mental health outcomes and the negative impact on those affected by trauma and mental illness in forming and sustaining relationships, there has to date been a failure to integrate relationship strengthening programs with mental health recovery and maintenance programs. It is, in our view, a major gap in the mental health system.<sup>16</sup>

Robust, positive social relationships are critical to physical and mental health outcomes. Social relationships—both quantity and quality—affect mental health, health behaviour, physical health, and mortality risk. Numerous studies have long established that social relationships have short- and long-term effects on health, for better and for worse, and that these effects emerge in childhood and cascade throughout life to foster cumulative advantage or disadvantage in health. A review of 148 studies concluded that ‘the influence of social relationships on the risk of death are comparable with well-established risk factors for mortality such as smoking and alcohol consumption and exceed the influence of other risk factors such as physical inactivity and obesity’ and that ‘physicians, health professionals, educators, and the media should take social relationships as seriously as other risk factors that affect mortality’<sup>17</sup>. Being in a stable relationship is linked to both physical and mental health benefits, including lower morbidity and mortality. Couples in mutually satisfying relationships provide each other with mutual support which buffers them from the adverse effects of stress.

On the flip side research has found that poor-quality or unhappy relationships have a high negative influence on physical and mental health.<sup>18</sup> Relationships that are prone to recurring conflicts or disappointments may contribute to the dysregulation of important bodily systems, such as the cardiovascular, neuroendocrine, and immune systems as well as mental wellbeing.

Struggling couples often report low mutual support and also suffer the negative effects of relationship distress, which is a significant source of psychological stress. Several studies have now found that individuals in distressed relationships report elevated psychological distress and psychological disorder, particularly depressive disorders. For many reasons, such as ongoing parental conflict, increased financial stress, substantially increased or decreased parental responsibility (depending on the children’s residency arrangement), changes in social networks, feelings of loss, and a mix of other varying emotional reactions, including anger, anxiety, loneliness, and sadness, separating and recently separated couples are also at high risk of adjustment problems and psychological distress. Distressed couples use health services substantially more than mutually satisfied couples and are overrepresented among those seeking mental health services. Some studies suggest that the loss of a partner (i.e. widowhood) leads to as much as a 25% increase in healthcare costs for the remaining partner relative to partners in satisfied relationships.<sup>19</sup>

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<sup>16</sup> This is illustrated in Figure 3 of the Draft Report which omits family and relationship services in non-health supports

<sup>17</sup> House, J. S., Landis, K. R., and Umberson, D. 1988. “Social Relationships and Health.” *Science* 241(4865): 540–5.

<sup>18</sup> Robles, T.F., Slatcher, R.B., Trombello, J.M. & McGinn, M.M. (2014). Marital quality and health: A meta-analytic review. *Psychological Bulletin*, 140 (1), 140-187.

<sup>19</sup> Jemima Petch, Jennifer Murray, Andrew Bickerdike, and Pamela Lewis (2014) *Psychological Distress in Australian Clients Seeking Family and Relationship Counselling and Mediation Services* Australian Psychologist 49 (2014) 28–3

Identifying and addressing relational problems may therefore have a positive impact on healthcare costs as a whole including the costs and consequences of mental illness.

The literature clearly establishes the correlation between attachment and impaired attachment and mental health outcomes. In a 30-year prospective study by infants who experienced poor attachment behaviours from their mothers at eight months of age were at higher risk for mental illness 30 years later.<sup>20</sup> Depression, anxiety, and substance use disorders have all been linked to insecure attachment<sup>21</sup> Other studies have shown that family members' emotional responses to a patient's bipolar episodes have a significant impact on how well (or not) the patient recovers from the episodes, according to 4 independent studies in 3 countries. Specifically, if the family is highly critical, hostile and overprotective, the patient will have more severe symptoms and more frequent relapses, compared with patients whose families are supportive and understanding. A 2-year randomized controlled trial of 101 bipolar patients, found that those who completed up to 21 sessions of family-focused therapy, in addition to medication, had fewer relapses, less severe symptoms and better medication adherence than a control group who received medication, two sessions of family education, and crisis intervention as needed.<sup>22</sup> Family focused therapy, in addition to medication, has been shown to improve recovery from bi-polar depression quicker and for longer than CBT or brief psychoeducation.<sup>23</sup>

Family focused interventions may be particularly useful as consumers transition from high intensity care and hospitalisation back into the community. In response to unmet demand RAV worked in partnership with Austin Health: Mental Health Service providing up to six sessions of family consultation working in collaboration with Austin Health clinicians who had a treatment or case management role for a client with a mental illness and possible alcohol and other drug (AOD) use. These clinicians came from a range of disciplines including mental health, nursing, psychology, social work, occupational therapy and medical. Guiding principles for this family work were drawn from Single Session Family Consultations (SSFC) and, where there were children of a parent with mental illness, COPMI Family Focus and other COPMI resources<sup>24</sup>. The Bouverie Centre's guide *From Individual to Family Work* was another valuable resource. Common family themes that emerged from family consultations are described in our response to Draft Recommendation 13.3- Family Focused and Carer Inclusive Practice on page 15 of this response.

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<sup>20</sup> Fan, A. P., Buka, S. L., Kosik, R. O., Chen, Y., Wang, S., Su, T., & Eaton, W. W. (2014). Association between maternal behavior in infancy and adult mental health: A 30-year prospective study. *Comprehensive Psychiatry*, 55, 283-289.2014),

<sup>21</sup> Heim, C., & Nemeroff, C. B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: Preclinical and clinical studies. *Biological Psychiatry*, 49(12), 1023-1039.

<sup>22</sup> David J. Miklowitz, PhD; Elizabeth L. George, PhD; Jeffrey A. Richards, MA; et al Teresa L. Simoneau, PhD; Richard L. Suddath, MD *Arch Gen Psychiatry*. 2003;60(9):904-912. doi:10.1001/archpsyc.60.9.90

<sup>23</sup> Miklowitz DJ et al, Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program. *Arch Gen Psychiatry*. 2007 Apr;64(4):419-26.

<sup>24</sup> COPMI, *COPMI Children of Parents with a Mental Illness: promoting better outcomes for children and families where a parent has a mental illness*.

**Conclusion:** There is strong evidence that relationships are critical to good mental health outcomes and should be considered as part of initial and ongoing assessment and referral. Treatment and case management plans for people using the mental health system should provide for access to relationship strengthening, couple, and family therapies that integrate systemic, emotional, relational, and neurophysiological approaches. Access to such programs can play a key role in recovery and in maintaining participation in work, education, and family and community life. Universal access to relationship and couple therapies can play a significant role in reducing the overall mental health burden on society.

#### Equity of Access Matched to Need: Improving Help-seeking

Access to suitable care at the earliest opportunity is critical to improving mental health outcomes. Yet, as stated in the draft report, “some 40% of those with mental ill-health have never accessed mental health services nor seen their GP about their condition, with young people particularly unlikely to seek help”. In our view, the requirement that consumers need a referral from a GP into the Better Access scheme is an unnecessary restriction. Extending referral authority to community based mental health nurses should, in our view, be considered as part of the reform<sup>25</sup>.

Improved assessment and referral practices should be developed in conjunction with strategies to encourage help-seeking behaviour and to ensure that services are more accessible to those less likely to seek help. For example, men are far less likely to seek medical support for a mental health problem than women. A survey commissioned by the Mental Health Foundation (2016) found that not only are men far less likely than women to seek professional support, they are also less likely to disclose a mental health problem to friends and family. The YouGov survey, polling more than 2,500 people who had mental health problems, showed 28% of men admitted that they had not sought medical help, compared with 19% of women. The survey found that a third of women, compared with a quarter of men, had told friends or family about their mental health problem within a month of it arising. More than a third of men, compared with a quarter of women, either waited more than two years or chose never to tell friends or family about their problem.<sup>26</sup>

Whilst there is a need to address cultural and societal influences, such as stigma and gender identity, through public health approaches, ease of access to services and diversifying entry points to mental health support can play an important role in improving earlier intervention. When RAV has conducted census surveys of clients accessing its relationship support services (such as couple counselling and family mediation) we have found substantial numbers of individuals reported experiencing symptoms associated with depression, anxiety and stress.<sup>27</sup> The findings have contrasted vividly with the Victorian State levels of depression and anxiety, suggesting that a greater proportion of newly presenting RAV clients, compared to the general Victorian population, are experiencing symptoms of anxiety and depression.<sup>28</sup> Similarly, over half the sample reported experiencing symptoms associated with abnormal stress, with over 25% of the sample reporting

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<sup>25</sup> In line with the proposed expanded role of mental health nurses recommended in the Commission’s draft report.

<sup>26</sup> As reported in Guardian 2016

<sup>27</sup> The survey used the DASS 21 (Depression Anxiety Stress Scales)

<sup>28</sup> Approximately 50% of the sample reported experiencing depression symptoms, with over 25% of the sample reporting symptoms that placed them in the “severe” or “extremely severe” category. Forty percent of the sample reported experiencing symptoms associated with anxiety, with 25% of the sample indicating that they experience symptoms that placed them in the “severe” or “extremely severe” category.

symptoms that placed them in the “severe” or “extremely severe” category. Whilst RAV practitioners, identifying mental health problems in clients, encourage them to seek help through GPs, it is clear that many don’t. A second study of psychological distress in 386 couples counselling clients from RAV found that mean distress on the Center for Epidemiologic Studies Short Depression Scale (CES-D 10) was 10 points above the cut-off score for depressive symptoms. These results underscore the importance of assessing the prevalence of psychological distress among individuals, couples, and families seeking relationship services from the NGO sector so that appropriate treatment planning can ensue.

**Conclusion:** We would argue that improving access to mental health support where consumers are already using services could significantly improve help-seeking, especially in men- many of whom at RAV are mandated to attend programs, such as, Post-separation Parenting programs, Family Dispute Resolution and Men’s Behaviour Change Programs. Creating better mental health referral pathways embedded in non-mental health services that people already attend could significantly improve outcomes. Community based mental health nurses located in schools, community NGO organisations, and workplaces, could play a critical role in improving referral rates for vulnerable sections of the population as well as supporting mental health awareness and wellbeing programs. They have, perhaps more than many GPs, the expertise to provide initial assessment and referral into the Better Access program and to provide appropriate follow up reviews.

#### **INFORMATION REQUEST 5.2 – MENTAL HEALTH TREATMENT PLANS**

In line with what we have stated elsewhere in this submission `RAV would argue that the current GP based system is not meeting current need in the community “Some 40% of those with mental ill-health have never accessed mental health services nor seen their GP about their condition, with young people particularly unlikely to seek help”. Men also are far less likely to seek medical support for a mental health problem than women. In line with the Commission’s proposed expanded role for Mental Health Nurses, we believe consideration should be given to community based mental health nurses located in schools, community organisations, primary healthcare centres and workplaces, having the authority to refer clients into the Better Access scheme. They have, perhaps more than many GPs, the expertise to provide initial assessment and referral into the Better Access program and to provide appropriate follow up reviews, liaising with GPs as required.

#### **DRAFT RECOMMENDATION 5.3: ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE**

We are not clear what Commission is recommending here. Headspace, the youth mental health service funded by the Primary Health Network, utilises a stepped care model of health care, for young people aged 12-25, based on the level of care assessed as required by the young person, from low to medium intensity. Young people are encouraged to access services before a problem becomes a crisis, when it is first noticed for a person and/or their friends and family. An empowering, supportive, therapeutic, problem-solving approach is used with young people, for their physical health and wellbeing and health decisions. However, our highest level of critical incident reporting at RAV, comes from out headspace centres and involves suicidal ideation or risk, or family violence risk, and in half of the cases, requires notification to Child Protection Services, an indicator that in many cases the problems the young people present with, require high level care. The young people from the regional towns where our headspaces are located have complex needs due to unemployment of carers, or the lack of job opportunities for young people, subsequent financial problems in families, exposure to chronic neglect, substance and alcohol abuse, sexual and physical abuse, homelessness, and family violence. These problems intersect and impact on the mental health of young people. In the cases of high risk of suicide, the only form of intervention is the involvement of triage, ambulance services and the emergency department of the local hospital, the issue is that there is nothing inbetween the low and high intensity of need, a large service gap. There are no specialised inpatient mental

health services for young people, and limited outpatient psychiatric services, a fragmented mental health care system.

Furthermore, the communities in East Gippsland in Victoria have been in the zone declared a disaster by the State Government, with raging and out of control bushfires in the month of January, which have taken lives, property, livestock, wildlife and torched the bush.

### **DRAFT RECOMMENDATION 5.5: ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY**

RAV support all proposals included in this recommendation. We believe that consumer choice would be expanded if accreditation to deliver group programs was extended to approved community organisations under the MBS. RAV and other community organisations would be able to deliver more eligible therapeutic groups than our current funding allows if this provision was introduced.

### **INFORMATION REQUEST 5.1 – LOW-INTENSITY THERAPY COACHES AS AN ALTERNATE TO PSYCHOLOGICAL THERAPISTS**

It is generally recognised that one of the most important distinguishing factors between psychotherapists and coaches is that coaches are generally not trained to help people who are facing mental illnesses. (Coaching can be said to be more goal directed, action-based, and outwardly defined.)

However, we would argue that evidenced based skill-based practices with proven mental health benefits, mindfulness for example, can be provided by suitably trained practitioners and that this could be considered more akin to coaching than traditional therapy.

To use mindfulness as an example: Evidence suggests that mindfulness meditation, breathing exercises and grounding exercises, have numerous health benefits, including increased immunity and reduction in psychological distress.<sup>29</sup> A systematic review of more than 20 randomized controlled trials in 2011 successfully demonstrated improvements in overall mental health, as well as its benefit for reducing risk of relapse from depression<sup>30</sup>. Similarly, substantial evidence exists that mindfulness has a positive impact on anxiety disorders such as post-traumatic stress disorder.<sup>31</sup> Several disciplines and practices can cultivate mindfulness, such as yoga, tai chi and qigong, but most of the literature has focused on mindfulness that is developed through mindfulness meditation — those self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calmness, clarity and concentration.

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<sup>29</sup> *ibid*

<sup>30</sup> Fjorback LO, Arendt M, Ornbøl E, Fink P, Walach H. Mindfulness-based stress reduction and mindfulness-based cognitive therapy: a systematic review of randomized controlled trials. *Acta Psychiatr Scand*. 2011 Aug;124(2):102-19.

<sup>31</sup> Hoge EA, Bui E, Palitz SA, Schwarz NR, Owens ME, Johnston JM, Pollack MH, Simon NM. The effect of mindfulness meditation training on biological acute stress responses in generalized anxiety disorder. *Psychiatry Res*. 2017 Jan 25

<sup>32</sup> Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist*, 61(3), 227–239. <https://doi.org/10.1037/0003-066X.61.3.227>

**Conclusion:** RAV would support a review of the proven efficacy of ‘skill-based’ practices in relation to mental health prevention and recovery and that where there is a solid evidence base access to such practices should be available as treatment options provided by suitably accredited practitioners.

### **DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS & DRAFT RECOMMENDATION 10.4 — CARE COORDINATION**

RAV supports these recommendations. In our experience in providing therapeutic support for clients with complex trauma, necessary case management and case-coordination is difficult and ad hoc without effective protocols and invariably requires more time than funding allows. These recommendations would be greatly enhanced by effective shared case management software.

### **DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE**

*Family-focused and carer-inclusive care requires mental health services to consider family members’ and carers’ needs and their role in contributing to the mental health of consumers.*

RAV fully supports these recommendations. We would strongly advocate for inclusion of suitably qualified couple and family therapists (experienced counsellors who have undergone specialist training) as eligible allied health professionals in their own right under the MBS Better Access Scheme. As discussed in our response to *Draft Recommendation 5.9 (Ensuring Access to the Right Level of Care)*, distressed relationships have a high negative influence on physical and mental health.<sup>33</sup> Several studies have now found that individuals in distressed relationships report elevated psychological distress and psychological disorder, particularly depressive disorders. Likewise, independently triggered depressive disorder (such as postnatal depression or a depressive disorder relating to a workplace injury) can put a significant strain on relationships, undermining their mutual support function. We would therefore support the proposal that couple and family therapy should form part of MBS mental health treatment plans where indicated. However, there is a risk, in our view, that vulnerable consumers might feel they would have to choose between individual and couple or family therapies, where both are needed to improve mental health outcomes. We would also note that individual and couple work should be conducted by different practitioners to ensure a balanced approach to the ‘dyadic’ approach of couple therapy- which is very different to a consultation that includes a partner.

We have also argued in response to *Draft Recommendation 5.9 (Ensuring Access to the Right Level of Care)* that treatment and case management plans for people using the mental health system should provide for access to relationship strengthening, couple, and family therapies that integrate systemic, emotional, relational, and neurophysiological approaches. Access to such family focused therapies can play a key role in recovery and in maintaining participation in work, education, and family and community life. We would therefore argue that the Commission’s recommendations do not go far enough in integrating family and relationship therapies in the mental health system and there is a risk that clients in need of up to 20 sessions psychological support per year (as proposed in recommendation 5.4) would be unable to further access family focused therapies if they count towards session limits for psychological therapy. For example, complex trauma treatment is generally longer than for many other presentations, and that while varying significantly

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<sup>33</sup> Robles, T.F., Slatcher, R.B., Trombello, J.M. & McGinn, M.M. (2014). Marital quality and health: A meta-analytic review. *Psychological Bulletin*, 140 (1), 140-187.

according to the client, is 'rarely...meaningful if completed in less than 10-20 sessions'.<sup>34</sup> As previously cited, a 2-year randomized controlled trial of 101 bipolar patients, found that those who completed up to 21 sessions of family-focused therapy, in addition to medication, had fewer relapses, less severe symptoms and better medication adherence than a control group who received medication, two sessions of family education, and crisis intervention as needed.

Family focused interventions may be particularly useful as consumers transition from high intensity care and hospitalisation back into the community. As described in our response In response to unmet demand RAV has previously partnered with Austin Health: Mental Health Service providing up to six sessions of family consultation working in collaboration with clinicians who had a treatment or case management role for a client with a mental illness or alcohol and other drug (AOD) use. These clinicians came from a range of disciplines including mental health, nursing, psychology, social work, occupational therapy and medical. Guiding principles for this family work were drawn from Single Session Family Consultations (SSFC) and, where there were children of a parent with mental illness, COPMI Family Focus and other COPMI resources<sup>35</sup>. The Bouverie Centre's guide *From Individual to Family Work* was another valuable resource. Common family themes that emerged from family consultations included the following.

- *Caring: Parents may find it difficult to juggle their multiple caring roles, such as looking after elderly parents and other children with mental health or social and emotional difficulties. Family members may need to adjust to changing roles within the family unit, particularly as in some cultures family members have well-established expectations around the roles of the father, son, mother etc.*
- *Mental illness: Where there is a history of mental illness (sometimes in conjunction with risk behaviour such as self-harm), parents and children may struggle with developmental tasks associated with independence. If a young adult has made significant progress in treatment, parents may find it difficult to adjust to allow for their child's increased autonomy. For example:*
  - *parents may be reluctant to support a young adult's independence around issues such as finance, studying or socialising with friends*
  - *parents may find it difficult to set clear limits and expectations, often to avoid conflict.*
  - *adult children may make unreasonable demands on parents for financial assistance.*

*Partners may also struggle with similar issues to those outlined above for parents.*

- *Family disharmony: Siblings may be frustrated with the attention the family member with a mental illness has gained. As a result of this, parents may feel guilty when they are caught between the demands of the adult child with a mental illness and criticism from other siblings who feel left out.*

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<sup>34</sup> Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.96, cited in Blue Knot Foundation 2019 Practice Guidelines for Clinical Treatment of Complex Trauma: Authors Kezelman C.A & Stavropoulos P.A.

<sup>35</sup> COPMI, *COPMI Children of Parents with a Mental Illness: promoting better outcomes for children and families where a parent has a mental illness.*

- *Burnout: Parents may experience burnout and drift apart from each other, particularly if one parent is pre-occupied with the family member who is mentally ill and the other appears absent.*

*Physical violence: The family may struggle to recover from physical violence when the family member with a mental illness was unwell and/or using AOD*

RAV and Austin Mental Health have been unable to continue this service due lack of funding, yet we believe that access to such programs can play a key role in recovery and in maintaining participation in work, education, and family and community life.

**Conclusion:** Whilst RAV welcomes this recommendation, we would argue that family focused and carer inclusive approaches should be more extensively trialled and evaluated in terms of contributing to sustained recovery than is being proposed here. Treatment and case management plans for people using the mental health system should provide for access to relationship strengthening, couple, and family therapies that integrate systemic, emotional, relational, and neurophysiological approaches. Therapies that improve the functioning of couple relationships and family systems should not be viewed as an add on, but integral to treatment. There is a risk here that vulnerable consumers might feel they would have to choose between individual and couple or family therapies, where both are needed to improve mental health outcomes. We would strongly advocate for inclusion of suitably qualified couple and family therapists (experienced counsellors who have undergone specialist training) as eligible allied health professionals in their own right under the MBS Better Access Scheme. Mental health plans need to accommodate the need for individual and couple therapies to be conducted in parallel with different practitioners for optimal results.

## **DRAFT FINDING 10.2 – SUPPORTING COLLABORATION BETWEEN SERVICE PROVIDERS**

*A range of approaches to collaboration, including co-location, alliances and networks, can improve service delivery and benefit consumers.*

*Depending on the scale and type of services involved, providers could consider formalising links using memorandums of understanding to create clear accountability structures and overcome barriers to collaboration.*

RAV strongly supports improved collaboration in mental health services. With mental health care being the third largest contributor to burden of disease in Australia an ongoing challenge is finding the optimal use of limited resources to increase accessibility and quality of patient care. At a systemic level, this creates tension between the need to maximise therapeutic benefits, while using resources efficiently to reach those in need. If properly implemented, we believe that the co-location and effective integration of relevant services in a single, accessible hub can significantly improve outcomes. Where this is not possible effective interagency collaboration where indicated as necessary to improve consumer outcomes requires a structured approach. In our view national guidelines and standards should be developed for collaborative MOUs in the mental health system.<sup>36</sup>

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<sup>36</sup>RAV's response to this section is informed by our extensive experience in participating in various collaborative service models and a recent literature review of effective collaboration models we have conducted in partnership with Swinburne University as the first stage to developing more effective workforce and corporate training and strengthening collaboration theory and practice content in tertiary education.

For the purposes of this submission we would draw attention to D'Amour et al.'s *Structuration Model of Collaboration*<sup>37</sup> and Minkman's *Development Model for Integrated Care*<sup>38</sup> as they comprehensively address essential elements of collaborative practice as well as the ways in which collaboration can occur in stages, potentially becoming more seamless over time. These approaches have undergone a degree of empirical evaluation<sup>39</sup>. The Structuration Model of Collaboration addresses inter-professional and inter-organisational collaboration, based on principles of collective action, which are derived from organisational sociology, and outlines four dimensions of collaboration:

- (1) Shared goals and vision
- (2) Internalisation
- (3) Formalisation
- (4) Governance

In summary, integrated service models are more likely to succeed if collaborative goals are formalised to ensure that:

- all partners are aware of what to expect from others involved in the collaboration, and what their responsibilities are to improve accountability
- there is a strong and active central body enabling the existence of a consensus
- there is shared consensual inter-agency leadership
- client centred approaches supersede other allegiances
- client management systems are integrated, with clear information-sharing protocols established
- inter-agency trust leading to effectiveness (and therefore efficiency) is built from opportunities to meet and by shared activities, such as professional development
- information is shared between the organisations to monitor progress.

Finally, Leutz's "five "laws" for integrating medical and social services remain relevant as a reality check against the proposition that collaboration is necessary or possible in every location or service intersection. Leutz takes a common-sense approach to naming the pragmatics and challenges inherent in collaboration.<sup>40</sup>

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<sup>37</sup> D'Amour, D., Goulet, L., Labadie, J. F., Martin-Rodriguez, L. S., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organisations. *BMC Health Serv Res*, 8, 188. doi:10.1186/1472-6963-8-188

<sup>38</sup> Minkman, M., Ahaus, K. T., & Huijsman, R. (2009). A four phase development model for integrated care services in the Netherlands. *BMC Health Serv Res*, 9, 42. doi:10.1186/1472-6963-9-42

<sup>39</sup> e.g., D'Amour et al., 2008, op cit.; Longpre, C., & Dubois, C. A. (2015). Implementation of integrated services networks in Quebec and nursing practice transformation: convergence or divergence? *BMC Health Serv Res*, 15, 84. doi:10.1186/s12913-015-0720-8; Minkman, M., Vermeulen, R. P., Ahaus, K. T., & Huijsman, R. (2011). The implementation of integrated care: the empirical validation of the Development Model for Integrated care. *BMC Health Serv Res*, 11, 177. doi:10.1186/1472-6963-11-177

<sup>40</sup> Leutz, W. (2005). Reflections on Integrating Medical and Social Care: Five Laws Revisited. *Journal of Integrated Care*, 13(5), 3-12. doi:10.1108/14769018200500034

**Conclusion:** RAV would argue for the development of national guidelines and standards for collaborative practice based on available best evidence models; and that collaborative services be independently evaluated to ensure an evidence base is built to guide future practice.

## Early intervention and prevention

### DRAFT RECOMMENDATION 17.1: PERINATAL MENTAL HEALTH

RAV supports universal screening as proposed.

**Comment:** However, screening needs to be linked with effective interventions- for example RAV's *early matters* program seeks to promote and strengthen healthy relationships to prevent families from entering a stress pathway. This multi-component program includes group programs and a Home Visiting/Outreach Service to work with families at three critical high-risk transition points:

- After the birth of a new baby – post-natal/post-partum relationships
- School readiness for kindergarten children with their parents
- Children in middle to late primary school and transitioning to high school.

### DRAFT RECOMMENDATION 17.2: SOCIAL AND EMOTIONAL DEVELOPMENT IN PRE-SCHOOL CHILDREN

**Comment:** Whilst RAV supports this proposal, we note that early childhood education staff are notoriously underpaid. Increasing their responsibility for children's social and emotional development linked to accredited professional development will result, in our view, in a legitimate expectation of appropriate salary increases, and this needs to be taken into account.

### DRAFT RECOMMENDATION 17.3: SOCIAL AND EMOTIONAL LEARNING PROGRAMS IN THE EDUCATION SYSTEM

RAV has long supported the inclusion of social and emotional learning programs in schools. Our successful *I like, like you* program is an early intervention relationships program that promotes the connection between healthy intimate relationships, and emotional health and wellbeing. With a strong emphasis on violence prevention and mental health promotion, the whole of school program introduces primary and secondary school students to the knowledge, practical skills and attitudes that promote healthy, equitable and respectful relationships match to their age.

We therefore strongly support the recommendation that Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum and that State and Territory departments of education should develop and use national guidelines to accredit social and emotional learning programs delivered in schools.

In developing guidelines we strongly advocate for whole of school models, such as *I like like you* and programs like MindMatters. The teacher professional development dimension of these models is central to enhancing the role of schools in broad population mental health promotion. Promoting the mental health and wellbeing of all young people should be regarded as a vital part of the core business of teachers by creating a supportive school environment that is conducive to learning. Teachers need to be comfortable and confident in

promoting and teaching for mental health. Specific, targeted interventions, provided within a whole-school framework, address the needs of the minority of students who require additional support.<sup>41</sup>

Whole of school approaches have also been shown to most effective in tackling bullying, including cyber bullying: “Given that a recent meta-analysis found that the most successful programs were those of longer duration and intensity, further research into capacity supports for schools to implement sustainable programs to reduce cyberbullying is paramount.”<sup>42</sup>

There has also been a whole of school model developed in the US to deal with trauma: “The goal of Helping Traumatized Children Learn is to ensure that children traumatized by exposure to family violence succeed in school. Research now shows that trauma can undermine children’s ability to learn, form relationships, and function appropriately in the classroom. Schools, which are significant communities for children, and teachers—the primary role models in these communities—must be given the supports they need to address trauma’s impact on learning.”<sup>43</sup>

Likewise the Penn Resiliency Program (developed in the US and adopted in many countries including the UK and Australia) is an evidence based universal programme delivered in the school setting. It is designed to build young people’s resilience and promote realistic thinking and adaptive coping. Students are taught skills and coping strategies which are designed to contribute towards a number of resilience competencies, such as emotional intelligence and flexible and accurate thinking. Participants also learn techniques for positive social behaviour, including assertiveness and negotiation: “From 1990 to 2007, we conducted a series of longitudinal, controlled studies to determine the effectiveness of a school-based cognitive-behavioral intervention designed to prevent depression and anxiety among middle school students. To date, about 20 controlled studies have been conducted on the Penn Resilience Program (PRP), by the Penn research team and by other research groups. These studies have included thousands of students between the ages of 9 and 14. Taken together, these studies indicate that the Penn Resilience Program can prevent and reduce the symptoms of depression and anxiety.”<sup>44</sup>

#### **DRAFT RECOMMENDATION 17.4: EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS**

RAV is strongly supportive of educational support for children with mental illness. Our *i-Connect* Family Mental Health Support Service, funded by the Australian Government Department of Social Services, delivers support to children and young people in East Gippsland at risk of or affected by mental illness. This free service is targeted at the 0 – 18 age group and aims to help children and young people stay engaged in education and learning, including sports activities, and to stay connected to their family, friends, and community. We work with the family or trusted adults in the lives of children and young people and have developed strong partnerships with local schools in the delivery of this program to ensure the lived

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<sup>41</sup> Johanna Wyn, Helen Cahill, Roger Holdsworth, Louise Rowling, Shirley Carson, MindMatters, a whole-school approach promoting mental health and wellbeing- Australian and New Zealand Journal of Psychiatry 2000; 34:594–601

<sup>42</sup> Natasha Pearce, Donna Cross, Helen Monks, Stacey Waters, and Sarah Falconer, Current Evidence of Best Practice in Whole-School Bullying Intervention and Its Potential to Inform Cyberbullying Interventions, Australian Journal of Guidance and Counselling ■ 1 Volume 21 | Issue 1 | 2011 | pp. 1–21 | DOI 10.1375/ajgc.21.1.1

<sup>43</sup> See Helping Traumatized Children Learn, partnership of Massachusetts Advocates for Children and Harvard Law School,

<sup>44</sup> <https://ppc.sas.upenn.edu/research/resilience-children>

experience of children and young people is understood by the school and appropriate educational support is provided. We believe that this model, which offers case management support to young people and their families working collaboratively with schools can significantly strengthen educational outcomes.

### **DRAFT RECOMMENDATION 17.5 – WELLBEING LEADERS IN SCHOOLS**

RAV supports the proposal that all schools employ a dedicated wellbeing leader who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support. Consistent with our response to *Recommendation 17.3*, we believe that the role of the wellbeing leader must be integrated with *whole of school* approaches. It is important that wellbeing leaders are not seen as the equivalent of sports teachers responsible for delivering a program separate from the rest of the curriculum.

### **INFORMATION REQUEST 17.1 – FUNDING THE EMPLOYMENT OF WELLBEING LEADERS IN SCHOOLS**

In general, RAV supports a mixed funding model that supports a consistent wellbeing model across all States and Territories preferably overseen and coordinated by a single national agency.

Funding in our view should be based on local need and the demographic profile of students in particular locations not formulated based solely on student numbers.

One approach would be to expand the current community engagement and education role of headspace to oversee and coordinate wellbeing programs for children from 5 to 26 through Primary school to Tertiary Education. This would ensure a consistent evidence-based approach, allowing for more effective evaluation, whilst allowing a degree of flexibility in response to local conditions. Familiarity with the headspace 'brand' from an early age would also contribute to destigmatising mental illness and encourage help-seeking. As is already the case headspace centres could work and collaborate with other agencies in the delivery of programs and act as a 'broker' linking schools with external providers for elements of their wellbeing programs, including professional development. headspace staff would provide consultancy and support to wellbeing officers and schools to match their wellbeing programs to local need. The headspace model requires the active participation of a youth advisory group- a model that should be applied to school wellbeing programs. We consider the input of students in the development and implementation of school wellbeing programs as critical in ensuring their relevance and success.

## **Healthcare workforce**

### **DRAFT RECOMMENDATION 11.1 – THE NATIONAL HEALTH WORKFORCE STRATEGY**

In implementing the National Health Workforce Strategy more needs to be done to ensure Recovery Orientated Principles are adopted in service delivery throughout the mental health system. As the current strategy states: "For some services and their staff, adopting recovery principles in service is a major change in their way of working with people with mental health problems. There are consequent implications for education and training curricula, professional development and the mix of skills and roles in service teams."

The ongoing transformation of the workforce will continue to be a challenge in the face of institutional and systemic norms established over many decades. It is vital that recovery orientated principles are embedded in all vocational and tertiary education. Consistent with themes we have developed through this submission we would argue that understanding trauma is essential to all mental health training and education, as is an understanding of the role of family focused modalities in supporting recovery.

In addition RAV believes that Interprofessional Collaborative Practice (ICP) within healthcare services is necessary to respond to the multi-faceted needs of consumers.<sup>45</sup> It also forms part of the solution to a fragmented mental healthcare system in Australia.<sup>46</sup> Interprofessional Education (IPE) is increasingly incorporated into tertiary education to teach students the skills and values of ICP so that they are prepared to collaborate when entering the workforce, but should be incorporated into health and social science university courses.<sup>47</sup> A wealth of IPE initiatives has demonstrated effectiveness in terms of enhancing student learning and appreciation for ICP, equipping them with skills necessary for collaborative practice. The mental health arena appears to pose unique challenges for IPE frameworks, such as addressing stigma among students and professionals<sup>48</sup>. Looking forward, further efforts are required to gain a clearer understanding of whether IPE initiatives lead to improved experiences for service-users, and to tailor this knowledge to enhance mental health care and outcomes. Formalising informal learning already taking place in workplaces to foster and develop collaboration is likely to be a cost-effective approach towards enhancing collaborative practice and consolidating learning from tertiary education into the healthcare system.<sup>49</sup>

RAV believes that the ethos of collaborative practice must be expanded upon and demonstrated more readily across mental healthcare services and professions to form part of a collective professional identity.

## **DRAFT RECOMMENDATION 22.2: A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY**

RAV fully supports the proposal to establish a new whole-of-government *National Mental Health Strategy* to improve population mental health over a generational time frame. A whole of government approach would recognise that:

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<sup>45</sup> RAV's response to this section is informed a recent literature review of effective collaboration models we have conducted in partnership with Swinburne University as the first stage to developing more effective workforce and corporate training and strengthening collaboration theory and practice content in tertiary education. A co-authored paper has been submitted to the *Journal of Interprofessional Care: Interprofessional Education and Interprofessional Collaborative Practice: A review of current initiatives in primary healthcare with a focus on mental health in Australia*.

<sup>46</sup> Minkman et al. (2009). Quality management model for integrated care: Results of a Delphi and concept mapping study. *International Journal for Quality in Health Care*, 21 (1), 66-75. doi:10.1093/intqhc/mzn048; Whiteford, H et al (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: a qualitative systematic review. *Australian & New Zealand Journal of Psychiatry*, 48 (10), 895-906.

<sup>47</sup> San Martin-Rodriguez, L., et al. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 19 (1), 132-147. doi: 10.1080/13561820500082677;

Sargeant, J., et al. (2010). Development and testing of a scale to assess interprofessional education (IPE) facilitation skills. *Journal of Continuing Education in the Health Professions*, 30 (2), 126-131; Willgerodt, M., et al. (2015). Interprofessional education and practice guide No. 4: Developing and sustaining interprofessional education at an academic health center. *Journal of Interprofessional Care*, 29 (5), 421-425.

<sup>48</sup> Maranzan, K. (2016). Addressing mental illness stigma in the psychology classroom. *Psychology Learning and Teaching*, 15 (3), 235-249.

<sup>49</sup> Nisbet, G., Dunn, S., Lincoln, M., & Shaw, J. (2016). Development of initial validation of the interprofessional team learning profiling questionnaire. *Journal of Interprofessional Care*, 30 (3), 278-287; Nisbet, G., Lincoln, M., & Dunn, S. (2013). Informal interprofessional learning: an untapped opportunity for learning and change within the workplace. *Journal of Interprofessional Care*, 27 (6), 469-475.

- the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health.
- Mental health is profoundly important to growth, development, learning and resilience.
- Mental wellbeing protects the body from the impact of life's stresses and traumatic events and enables the adoption of healthy lifestyles and the management of long term illness. It is associated with better physical health, positive interpersonal relationships and socially healthier societies.
- Mental wellbeing is a valuable resource for individuals, families and communities, and ultimately the economy. It helps people to achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society.<sup>50</sup>

In our view an effective National mental Health Strategy will require the integration of six key elements:

1. Reconfiguring the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model). RAV believes that improved assessment and referral practices should be developed in conjunction with strategies to encourage help-seeking behaviour to ensure that services are more accessible to those less likely to seek help. For example, men are far less likely to seek medical support for a mental health problem than women. As stated in the Commission's draft report, "some 40% of those with mental ill-health have never accessed mental health services nor seen their GP about their condition, with young people particularly unlikely to seek help". In our view, the requirement that consumers need a referral from a GP into the Better Access scheme is an unnecessary restriction. Extending referral authority to community based mental health nurses should, in our view, be considered as part of the reform<sup>51</sup>. This will contribute to the necessary development of the fair and equitable resourcing of mental health services wherever anyone lives, which should include expansion of online and digital treatment options as recommended in the draft report.
2. *The implementation of an effective public health strategy that combines education, promotion, and prevention strategies.* A public mental health approach will be concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems.<sup>52</sup> Universal interventions that promote mental wellbeing across whole populations should be integrated with progressively targeted interventions to address specific needs among more vulnerable and at-risk groups. A public mental health plan will aim to build literacy from an early age in mental and emotional wellbeing and promote effective mental health maintenance, resiliency and stress management practices throughout life. Increasing mental health and wellbeing literacy

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<sup>50</sup> Foresight Mental Capital and Wellbeing Project. (2008). Final Project Report. The Government Office for Science, London. 7 Chida Y, Steptoe A. (2008); Positive psychological wellbeing and mortality: a quantitative review of prospective observational studies. *Psychosom Med.* 70(7): 741-56.; Pressman, S.D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin* 131, 925–97.

<sup>51</sup> In line with the proposed expanded role of mental health nurses recommended in the Commission's draft report.

<sup>52</sup> Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016) London: Faculty of Public Health and Mental Health Foundation

across the whole population will reduce stigma and discrimination actively supporting strength-based approaches in the mental health system. Public Mental health is fundamental to public health in general because mental health is a determinant and consequence of physical health as well as a resource for living.

3. *A life course approach to mental health that emphasizes prevention and early intervention at every life stage:* We strongly endorse proposals to improve prevention and early intervention strategies in schools. However, we argue that a new mental health strategy for Australia should adopt a life course approach that emphasizes prevention and early intervention at every life stage – intrauterine period, early childhood, adolescence, youth, middle age and old age, with a particular focus on key life transitions<sup>53</sup>. In our view, consideration of the mental health needs and challenges associated with an ageing population is a significant omission in the current report. A life course framework is consistent with the WHO’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Therefore, it focuses not only on reducing mortality and morbidity, but on the impact of health determinants, the economic, environmental and social conditions, on health and well-being at various stages in life.”
4. *The integration of relationship-based intervention in mental health treatment plans:* Often the foundations of mental health are laid down in infancy in the context of family relationships and social relationships are protective of mental health for all people. Distressed relationships have a significant impact on mental and physical health. Trauma, particularly Complex trauma arising from childhood abuse is highly disruptive of relationships. Mental illness often impairs people’s capacity to form and maintain relationships. Targeted services strengthening and repairing relationships at all life phases are integral to an effective mental health strategy. Family focused interventions should be available as part of all mental health treatment plans.
5. *A new mental health strategy must adopt a trauma informed approach to be effective:* A major gap in mental health services not specifically identified in the Commission’s draft report is the role trauma plays in mental illness. There is significant increased risk for any DSM-IV psychiatric disorders following exposure to childhood abuse. Such an exposure is associated with increased risks for a range of mental health disorders, including substance disorders, psychotic disorders, mood and anxiety disorders, and any suicide attempt.<sup>54</sup> Childhood trauma has been associated with a poorer response in resistant-depression, obsessive–compulsive disorder and schizophrenia<sup>55</sup> In routine

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<sup>53</sup> *Birth, transitions through education and developmental stages; pregnancy, relationship formation; divorce (separation); retirement; age-related disability.*

<sup>54</sup> any substance use disorders (OR = 1.24 [1.07, 1.44]), psychotic disorders (OR = 1.27 [1.00, 1.61]), any mood disorders (OR = 1.41 [1.25, 1.60]), any anxiety disorders (OR = 1.56 [1.38, 1.77]), and any suicide attempts (OR = 1.57 [1.26, 1.96]) (Sugaya et al. . Child physical abuse and adult mental health: a national study. *J Trauma Stress.* 2012;25:384–92.)

<sup>55</sup> Douglas KM, Porter RJ. The effect of childhood trauma on pharmacological treatment response in depressed inpatients. *Psychiatry Res.* 2012;200:1058–61; Shamseddeen W, Asarnow JR, Clarke G, Vitiello B, Wagner KD, Birmaher B, Keller MB, Emslie G, Iyengar S, Ryan ND, McCracken JT, Porta G, Mayes T, Brent DA. Impact of physical and sexual abuse on treatment response in the Treatment of Resistant Depression in Adolescent Study (TORDIA). *J Am Acad Child Adolesc Psychiatry.* 2011;50:293–301; Hassan

practice, a trauma assessment should be undertaken to ensure that appropriate treatment options are provided; and where indicated, addressing childhood trauma should be a focus of early intervention strategies and approaches. *(A fuller discussion is provided in our response to Draft Recommendations 5.9: Ensuring Access to the Right Level of Care on page 6 of this response)*

6. *An effective interdisciplinary workforce trained in recovery orientated principles:* RAV believes that Interprofessional Collaborative Practice (ICP) within healthcare services is necessary to respond to the multi-faceted needs of consumers.<sup>56</sup> The ethos of collaborative practice and recovery orientated practice must be expanded upon and demonstrated more readily across mental healthcare services and professions to form part of a collective professional identity. *(We elaborate on our arguments in our response to Healthcare Workforce section recommendations on page 21 of this response)*

## Monitoring Reporting and Evaluation

There are a number of recommendations throughout the draft report relating to improved monitoring and evaluation, which RAV supports. We strongly support the proposal that the National Mental Health Commission should have the statutory authority to lead the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors. Whilst this does not preclude providers working with other independent agencies in the evaluation of programs, the proposal would ensure consistency of evaluation approaches allowing for more effective comparative analysis.

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AN, de Luca V. The effect of lifetime adversities on resistance to antipsychotic treatment in schizophrenia patients. *Schizophr Res.* 2015;161:496–500; Semiz UB, Inanc L, Bezgin CH. Are trauma and dissociation related to treatment resistance in patients with obsessive-compulsive disorder? *Soc Psychiatry Psychiatr Epidemiol.* 2014;49:1287–96.

<sup>56</sup> RAV's response to this section is informed a recent literature review of effective collaboration models we have conducted in partnership with Swinburne University as the first stage to developing more effective workforce and corporate training and strengthening collaboration theory and practice content in tertiary education. A co-authored paper has been submitted to the *Journal of Interprofessional Care: Interprofessional Education and Interprofessional Collaborative Practice: A review of current initiatives in primary healthcare with a focus on mental health in Australia.*